

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. **36693**Registered No. **35**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of **Ada** Registration District No. **32**  
City of **Boise** Primary Registration District No. **410** State **Idaho**

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**William Grant**

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
(Write the word.)

## 6. DATE OF BIRTH

**Feb. 4 1922**  
(Month) (Day) (Year)

## 7. AGE

**Stillborn**IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.....  
(b) General nature of industry, business or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country)

**Boise Ida**

## 10. NAME OF FATHER

**William B. Grant**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Idaho**

## 12. MAIDEN NAME OF MOTHER

**Traver P. Hillman**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Bresden Germany**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**William E. Grant**

(Address)

**1118 Lemay Street Boise**

## 15.

Filed

19

**W. H. J.**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Feb. 4 1922**  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to ..... 19.....  
that I last saw him alive on..... 19.....  
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

**Still birth, had been dead for days or 2 weeks**

..... (Duration) ..... Yrs..... mos..... ds.

Contributory  
(Secondary)

..... (Duration) ..... yrs..... mos..... ds.

(Signed)

**L. O. McCella M. D.****2/6 1922**(Address) **Boise Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

**St John Cemetery**

## DATE OF BURIAL

**2/6 1922**

## 20. UNDERTAKER

**Schreiber & Sidenfaden**

## ADDRESS

**Boise Ida**

2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

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## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **36698**  
Registered No. **30**

## 1. PLACE OF DEATH

County of **Ada** Registration District No. **132**  
City of **Boise** Primary Registration District No. **VITAL 419 No. 13**  
St. **ID**

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Baby Peroni**

If death occurs in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
(Write the word.)

6. DATE OF BIRTH **Feb 2nd 1922**  
(Month) (Day) (Year)

7. AGE **1** IF LESS than 1 day how many hrs. or min.?  
Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work **none**  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) **Boise, Idaho**

## 10. NAME OF FATHER

**Vincent Peroni**

## 11. BIRTHPLACE OF FATHER

(State or Country) **Italy**

## 12. MAIDEN NAME OF MOTHER

**Matilda Simpson**

## 13. BIRTHPLACE OF MOTHER

(State or Country) **England**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Vincent Peroni**

(Address) **Boise Idaho**

15.

Filed **Feb 2nd 1922**

Local Registrar

## 16. DATE OF DEATH

**Feb 2nd 1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **1922** to **1922**

that I last saw him alive on **1922**

and that death occurred on the date stated above, at **2 P.M.**

The CAUSE OF DEATH\* was as follows:

**4 1/2 mrs fortus**

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Chas. E. Green**

M. D.

19. (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**St. Johns Cemetery**

**2/2 1922**

## 20. UNDERTAKER

## ADDRESS

**Shreiber & Hidenfaden Boise Idaho**

**Dr. Peroni**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 37603

Registered No. 70

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH Registration District No. 3  
County of Canyon Primary Registration District No. 2007  
City of (NALLA) St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Porter

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.  
(Write the word.)

6. DATE OF BIRTH Still born.  
(Month) (Day) (Year)

7. AGE 6th month  
IF LESS than 1 day  
how many.....hrs. or  
.....min?

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work.  
(b) General nature of industry business, or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Canyon Co.

## 10. NAME OF FATHER

Andy Porter

## 11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

## 12. MAIDEN NAME OF MOTHER

Bella Cunningham

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. L. Adams

(Address) R. F. 4 Parma Ida

## 15.

Filed 3/20/1922 Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16. DATE OF DEATH

March 20 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH\* was as follows:

Still born due to Influenza of mother

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Sarazin M. D.  
3/20 1922 (Address) 7455a Ore

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Canyon Co Ida 3/20 1922

## 20. UNDERTAKER ADDRESS

No ✓

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

1. PLACE OF DEATH **RECEIVED**  
 County of **Brigham** Registration District No. **137**  
 City of **Blackfoot** State of **Idaho** Registration District No. **007**  
 City of **Blackfoot** No. **20 South Shelling** St.)  
 If death occurs away from usual residence, give facts called for under special information.

## CERTIFICATE OF DEATH

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. **S 37935**  
 Registered No. **73**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

**Baby Clark**

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
 (Write the word.)

## 6. DATE OF BIRTH

**April 25 1922**  
 (Month) (Day) (Year)

## 7. AGE

**Still born**

IF LESS than 1 day  
 how many..... hrs.  
 or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

**None**

## 9. BIRTHPLACE

(State or Country)

**Blackfoot Ida**

## 10. NAME OF FATHER

**Louis E Clark**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Berkeley, Calif**

## 12. MAIDEN NAME OF MOTHER

**Margaret Duncan**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Mont**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**L E Clark**

(Address)

**Blackfoot**

## 15. Filed

**April 26 1922 Mrs Walter E. Palmer**  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**April 25 1922**  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased **on**  
**4/25 1922** to **19**  
 that I last saw h. **give on** **19**  
 and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

**Still born**  
**signature**

(Duration)..... Yrs..... mos..... ds.

Contributory  
 (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

**W. H. Harshbarger M. D.**

(Address) **Blackfoot**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Grove City Cem**

**4-26-1922**

## 20. UNDERTAKER

## ADDRESS

**E. R. Cyli**

**13.**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

1. PLACE OF DEATH **Frederick** JUN 5 1932 Registration District No. **103**  
 County of **Fremont** BUREAU OF VITAL STATISTICS Registration District No. **8**  
 City of **Ashton** STATISTICS St.)

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. **S 38067**  
 Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Baby Henry**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED  
 (Write the word.)

6. DATE OF BIRTH

**May 11 1932**  
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs.  
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Farnum Idaho**

10. NAME OF FATHER

**Claud Henry**

11. BIRTHPLACE OF FATHER

(State or Country) **Neb.**

12. MAIDEN NAME OF MOTHER

**ella Helm.**

13. BIRTHPLACE OF MOTHER

(State or Country) **Neb.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Homer Henry**

(Address) **Marysville Idaho**

15.

Filed **19**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

**May 11 1932**  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **19** to **19**  
 that I last saw him alive on **May 11** 19 **22**  
 and that death occurred on the date stated above, at **12 P.M.**

The CAUSE OF DEATH\* was as follows:

**not known**

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **E. V. Davis** M. D.

**May 11 1932** (Address) **Ashton Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

**Ashton Idaho**

DATE OF BURIAL

**May 13 1932**

20. UNDERTAKER

**Lewis Kiser**

ADDRESS

**Ashton Idaho**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **S 38068**  
Registered No. ....

1. PLACE OF DEATH ..... 103  
County of **Fremont** .....  
City of **Ashton** .....  
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Baby Henry**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word.)

6. DATE OF BIRTH

**May 11th 1922**  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) **Fremont Idaho**

10. NAME OF FATHER

**Claud Henry**

11. BIRTHPLACE OF FATHER

(State or Country) **Neb.**

12. MAIDEN NAME OF MOTHER

**Ella Helm.**

13. BIRTHPLACE OF MOTHER

(State or Country) **Neb.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Homer Henry**  
(Address) **Marysville Idaho.**

15.

Filed **May 11 1922** Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

**May 11th 1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Ashton** 19 to **Ashton** 1922  
that I last saw h. **in** alive on **May 11** 1922  
and that death occurred on the date stated above, at **12 P.M.**  
The CAUSE OF DEATH\* was as follows:  
**Asphyxia**

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **E. J. Harris** M. D.

**May 11 1922** (Address) **Ashton Idaho.**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL  
**Ashton Idaho**

DATE OF BURIAL  
**5/12/22**

20. UNDERTAKER  
**Lewis Kiser**

ADDRESS  
**Ashton Idaho.**

Stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (Secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Deafity," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Worms" ~~but~~ a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably, ~~not~~ if possible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of ~~skull~~, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## 1. PLACE OF DEATH

County of *Gem*City of *Emmett*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## CERTIFICATE OF DEATH

Registration District No. ....

Primary Registered District No. ....

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

38072

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.  
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

May 14 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth May 14 to death May 14 1922.

that I last saw him alive on May 14 1922.

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Blue Baby

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed)

M. D.

5/14/1922 (Address) Emmett

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Ida

5/15 1922

20. UNDERTAKER

ADDRESS

Ed Bucknum

Emmett

Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## CERTIFICATE OF DEATH

Registration District No.

Primo of Vital Statistics

Registration District No.

St.)

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. **38086**  
 Registered No. **31**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

## 7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

19

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month)

(Day)

(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Duration)

yrs.

mos.

ds.

(Signed)

2-25-22

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

RECEIVED

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 3951

County of Teton

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby T Highbee

File No.

Registered No. 1068

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

Single

## 6. DATE OF BIRTH

May 8 1922

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

D E Highbee

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Pearl Courtney

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D E Highbee

(Address)

Pocatello Idaho

## 15.

Filed

65

19

22

D E Highbee

Local Registrar

## 16. DATE OF DEATH

May 8 1922

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still Born - Premature

(Duration) Yrs. mos. ds.

Contributory (Secondary) Albuminuria in Mother

(Duration) yrs. mos. ds.

(Signed) J H Kaeder M. D.

5/9 1922 (Address) Pocatello Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Pocatello Idaho

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Forest Cemetery

May 9 1922

## 20. UNDERTAKER

## ADDRESS

R B Mooney Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



## 1. PLACE OF DEATH

County of *Nez Perce*City of *Lewiston* (No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*"Stillborn" Miller*

## CERTIFICATE OF DEATH

Registration District No. *96*Primary Registration District No. *1009*State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *S 38176*Registered No. *873*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED*Female White Single*  
(Write the word.)

6. DATE OF BIRTH

*4 1 1922*  
(Month) (Day) (Year)

7. AGE

*Stillborn*IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)*none*

9. BIRTHPLACE

(State or Country)

*Idaho.*

10. NAME OF FATHER

*Otto F. Miller*

11. BIRTHPLACE OF FATHER

(State or Country)

*Germany*

12. MAIDEN NAME OF MOTHER

*Mabel Thayer.*

13. BIRTHPLACE OF MOTHER

(State or Country)

*S. Dak.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Otto F. Miller.*

(Address)

*Lewiston Ida*15. *May 8 1922 Susan E. Bruce*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*4 - 1 - 22*  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from  
*Apr 1<sup>st</sup> 1922 to Apr 1<sup>st</sup> 1922*

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *O. C. Carson* M. D.19. (Address) *Lewiston Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Lewiston Ida**4/3/22*

20. UNDERTAKER

ADDRESS

*Vassar Lumber Co.,**Lewiston Ida*

A. stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

A 2 B

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

S 28 38332

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Carroll  
City of Pocatello

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. 3856

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Robert Earl Young Bird

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Married)

## 6. DATE OF BIRTH

June 11 1922  
(Month) (Day) (Year)

## 7. AGE

Still Born  
Yrs. Mos. ds. IF LESS than 1 day  
how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).None

## 9. BIRTHPLACE

(State or Country)

Pocatello

## 10. NAME OF FATHER

Mr F. Bird

## 11. BIRTHPLACE OF FATHER

(State or Country)

Nashville Mo

## 12. MAIDEN NAME OF MOTHER

Eva Greenwood

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Oklahoma

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr F. Bird

(Address)

Pocatello

## 15.

Filed 6-12-1922J. R. Young  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

June 11 1922  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from June 11 1922 to June 11 1922 that I last saw him alive on June 11 1922 and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) W. L. Brown M. D.June 11 1922 (Address) Pocatello Id

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

St. Lawrence6/12 1922

## 20. UNDERTAKER

## ADDRESS

M. J. MacdonPocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *2d ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1013

FORM V. S. No. 5-A—25 M. 1-19.

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

## 4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

## 6. DATE OF BIRTH

## 7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed 6 20 1922

Local Registrar

## 16. DATE OF DEATH

## 17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

The CAUSE OF DEATH\* was as follows:

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

g/19 1922 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **S 38710**  
Registered No. **122**

## 1. PLACE OF DEATH

Registration District No. **2**  
County of **Ada** Primary Registration District No. **1004**  
City of **Boise** **Boise** (St.)

If death occurs away from usual residence, give fact called for under special information.

**BUREAU OF VITAL STATISTICS**  
2. FULL NAME

**Infant Harris**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

**M**

## 4. COLOR OR RACE

**White**

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

**Single**

## 6. DATE OF BIRTH

**July 25 1922**  
(Month) (Day) (Year)

## 7. AGE

**Yrs. Mos. ds.** IF LESS than 1 day how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

**None**

## 9. BIRTHPLACE

(State or Country)

**Boise Idaho**

## 10. NAME OF FATHER

**J. Emer Harris**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Utah**

## 12. MAIDEN NAME OF MOTHER

**Maudel Woodsey**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Unknown**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

**2417 No 20 St**

## 15.

Filed

**July 26 1922**

**R. H. Hall**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**July 25 1922**  
(Month) (Day) (Year)

## 17. HEREBY CERTIFY, That I attended deceased from July 25 1922 to July 25 1922

that I last saw him alive on **July 25 1922** and that death occurred on the date stated above, at **11** M.

The CAUSE OF DEATH was as follows:

**Still birth**

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

**Edward J. Binner**

(Address)

**Boise Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Morris H. Lindholm July 26 1922**

## 20. UNDERTAKER

## ADDRESS

**Binner & Tribe Boise Id**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer, Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

AUG 1922

BUREAU OF VITAL STATISTICS

No.

Registration District No.

Registration District No.

St.)

File No.

Registered No.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

June 19

1922

Ed E. E. E.

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1922 to May 29, 1922

that I last saw him alive on May 29, 1922

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH was as follows:

Contributory  
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

(Duration)

Yrs.

mos.

ds.

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1013

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

RECEIVED

Registration District No. 100

County of

Madison

AUG 8 1922

Registration District No. 2178

City of

Lynon

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Beek

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. S 38796

Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

F

W

Single

(Write the word.)

6. DATE OF BIRTH.

July 24 1922  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many hrs. or  
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

Still Born

9. BIRTHPLACE

(State or Country)

Lynon

10. NAME OF FATHER

Orvil Beek

11. BIRTHPLACE OF FATHER

(State or Country)

Lafayette Idaho

12. MAIDEN NAME OF MOTHER

Alice Shap

13. BIRTHPLACE OF MOTHER

(State or Country)

Mills Creek Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. R. Pyatt

(Address)

Lynon Idaho

15.

Filed

7/27

1922

J. R. Pyatt

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

189-6

16. DATE OF DEATH

July 24 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Miscellaneous on the road  
Home. no Dr. a  
Midwife attended her

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Signed) J. R. Pyatt Reg. # 100

7/27 1922 (Address) 1 R. Pyatt

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Smydel

7/25 1922

20. UNDERTAKER

ADDRESS

J. R. Pyatt

R. Pyatt

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

17016

FORM V. S. No. 5-25 M. 1-19.

RECEIVED  
 1. PLACE OF DEATH *Shoshone* Registration District No. *70*  
 County of *Shoshone* Registration District No. *10*  
 City of *Wallace* *Wallace Hospital* File No. *S 38824*  
 If death occurs away from usual residence, give facts called for under special information.  
 2. FULL NAME *Infant John W. Coumerilh* If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*  
 (Write the word.)  
 6. DATE OF BIRTH *June 2 1922*  
 (Month) (Day) (Year)

7. AGE *still born* IF LESS than 1 day how many hrs. or min.?  
 Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19

19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. D.

19

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Mullan Ida**6-3 1922*

## 20. UNDERTAKER

## ADDRESS

*B. B. Mottell**Wallace*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **38877**  
Registered No. **202**

## 1. PLACE OF DEATH.

County of **Ada** Registration District No. **10**  
City of **Bosse** Secondary Registration District No. **10**  
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Branguard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

**I**

## 4. COLOR OR RACE

**White**

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

**Single**  
(Write the word.)

## 6. DATE OF BIRTH.

**August 22, 1922**  
(Month) (Day) (Year)

## 7. AGE

**Yrs. Mos. ds.**

IF LESS than 1 day  
how many ..... hrs. or  
..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

**None**

## 9. BIRTHPLACE

(State or Country)

**Bosse Idaho**

## 10. NAME OF FATHER

**R. R. Branguard**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Kansas**

## 12. MAIDEN NAME OF MOTHER

**Bernie Marie Callen**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Nebraska**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **R. R. Branguard**

(Address) **Bosse Idaho 10087**

## 15.

Filed **Aug 28 1922**

**G. H. Pratt**

Local Registrar

## 16. DATE OF DEATH

**Aug - 22**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 22 1922** to **Aug 22 1922**

that I last saw him alive on **Aug 22 1922** and that death occurred on the date stated above, at **4 P. M.**

The CAUSE OF DEATH\* was as follows:

**Still Born**

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **R. H. Torney** M. D.

1922 (Address) **Bosse**

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

**Morris Hill Cemetery**

## DATE OF BURIAL

**Aug 28 1922**

## 20. UNDERTAKER

**Summers & Trebo Boise Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

\* A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **S 38934**

1. PLACE OF DEATH  
County of Burse  
City of Swartzburg  
If death occurs away from usual residence, give facts called for under special information.  
2. FULL NAME Baby Nelson  
Registration District No. 12  
Primary Registration District No. 12  
St. )

Registered No. ....  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male  
4. COLOR OR RACE  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word.)

16. DATE OF DEATH  
Aug 9 1922  
(Month) (Day) (Year)

6. DATE OF BIRTH  
Aug 9  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
..... 19..... to ..... 19.....  
that I last saw h..... alive on ..... 19.....  
and that death occurred on the date stated above, at..... M.  
The CAUSE OF DEATH\* was as follows:

7. AGE still born  
..... Yrs. .... Mos. .... ds.  
IF LESS than 1 day  
how many..... hrs.  
or..... min.?

..... (Duration) ..... Yrs. .... mos. .... ds.  
Contributory  
(Secondary)  
..... (Duration) ..... yrs. .... mos. .... ds.  
(Signed) ..... M. D.  
..... 19..... (Address) .....

8. OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

9. BIRTHPLACE  
(State or Country)

10. NAME OF FATHER J Baker

11. BIRTHPLACE OF FATHER  
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Baker

13. BIRTHPLACE OF MOTHER Burse  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) .....  
(Address) .....

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. .... mos. .... days. In the State..... yrs. .... mos. .... days  
Where was disease contracted if not at place of death?  
Former or usual residence .....

15. Filed Aug 10 1922 Mrs El Robson  
Local Registrar

19. PLACE OF BURIAL OR REMOVAL Placerville DATE OF BURIAL Aug 9 1922

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bonanza  
 City of Idaho Falls

Registration District No. 73  
 Primary Registration District No. 2140  
 (No. Spencer St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Alma H. Hume

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 38951  
 Registered No. 71

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
 (Write the word.)

6. DATE OF BIRTH June 27 22  
 (Month) (Day) (Year)

7. AGE Born dead IF LESS than 1 day  
 how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho Falls  
 (State or Country)

10. NAME OF FATHER Ray Ernest

11. BIRTHPLACE OF FATHER Idaho  
 (State or Country)

12. MAIDEN NAME OF MOTHER Alma Hume

13. BIRTHPLACE OF MOTHER Idaho  
 (State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray Ernest  
 (Address) Idaho Falls

15. Filed July 17 19 22 W. Hume  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 27 19 22  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH\* was as follows:

Stillborn baby

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

July 5 19 22 (Address) Idaho Falls

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls June 28 19 22

20. UNDERTAKER Idaho Falls ADDRESS

2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill*; (a) *Salesman, (b) Grocery*; (a) *Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

AC 15

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
FILE NO. **38953**  
Registered No. **10**

1. PLACE OF DEATH  
County of **Boone**  
City of **Idaho Falls**  
Registration District No. **23**  
Primary Registration District No. **214-0**  
St. **Idaho Falls**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Infant Reed**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male**  
4. COLOR OR RACE **White**  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
(Write the word.)

6. DATE OF BIRTH **Apr. 9, 1922**  
(Month) (Day) (Year)

7. AGE **Boys 14**  
Yrs. Mos. ds.  
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **None**  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Idaho Falls**  
(State or Country)

10. NAME OF FATHER **Elias Reed**

11. BIRTHPLACE OF FATHER **Id.**  
(State or Country)

12. MAIDEN NAME OF MOTHER **Elizabeth McGowan**

13. BIRTHPLACE OF MOTHER **Idaho**  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **Elias Reed**  
(Address)

15. Filed **July 14, 1922**  
Local Registrar

16. DATE OF DEATH **Apr. 9, 1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Apr 9, 1922**, to **Apr 9, 1922**  
that I last saw him alive on **Apr 9, 1922**  
and that death occurred on the date stated above, at **4 A.M.**  
The CAUSE OF DEATH\* was as follows:

**DTL L**  
(Duration) Yrs. mos. ds.  
Contributory (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) **W. J. ...** M. D.  
(Address) **Idaho Falls, Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.  
Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Idaho Falls** DATE OF BURIAL **Apr 10, 1922**

20. UNDERTAKER **Idaho Falls** ADDRESS **Idaho Falls**

on demand

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

RECEIVED

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Elmore Registration District No. 34  
 City of Mountain Home Registration District No. 2020  
 (No. \_\_\_\_\_) (St. \_\_\_\_\_)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. S 39025  
 Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single  
 (Write the word.)

## 6. DATE OF BIRTH

6 — 1 — 1922  
 (Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs.  
 or min.?

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Ida

## 10. NAME OF FATHER

Claude M. Cobe

## 11. BIRTHPLACE OF FATHER

(State or Country) Oregon

## 12. MAIDEN NAME OF MOTHER

Pearl Webb

## 13. BIRTHPLACE OF MOTHER

(State or Country) Tenn

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claude M. Cobe

(Address) Mountain Home, Ida

## 15.

Filed 7-1-22

J. E. Evans  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

6 — 1 — 1922  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

6-1-1922 to 6-1-1922  
 that I last saw him alive on 11:30 A.M.  
 and that death occurred on the date stated above, at 11:30 A.M.  
 The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Evans M. D.

7-1-1922 (Address) Mountain Home, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Mountain Home, Ida 6-1-1922

## 20. UNDERTAKER

## ADDRESS

W. H. Conover Mountain Home, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. \_\_\_\_\_  
County of San Juan Registration District No. 6  
City of Emmett St.)

File No. 39037

Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Mr. J. C. Hunter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

## 6. DATE OF BIRTH

Aug 12 1922  
(Month) (Day) (Year)

## 7. AGE

Stillborn

IF LESS than 1 day  
how many ..... hrs. or  
..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

## 9. BIRTHPLACE

(State or Country) Emmett

## 10. NAME OF FATHER

Lloyd Hunter

## 11. BIRTHPLACE OF FATHER

(State or Country) Oregon

## 12. MAIDEN NAME OF MOTHER

Ruth May England

## 13. BIRTHPLACE OF MOTHER

(State or Country) Oklahoma

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. C. Hunter  
Emmett

## 15.

Filed 8/12 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Aug 12 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY That I attended deceased from

at birth 1922  
that I last saw him alive on 1922

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. C. Hunter M. D.8/12/22 (Address) Emmett

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Emmett Ida8/13 1922

## 20. UNDERTAKER

## ADDRESS

HunterEmmett

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

123

FORM V. S. No. 5-25 M. 10

RECEIVED

SEP 10 1922

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH Wadsworth Registration District No. 100  
 County of Madison Registration District No. 2178  
 City of Payson (No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Wardell

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 39089  
 Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Bale  
 (Write the word.)

6. DATE OF BIRTH.

Aug-15-1922  
 (Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
 (b) General nature of industry, business, or establishment in which employed (or employer)...

Bale

9. BIRTHPLACE

(State or Country)

Payson -

10. NAME OF FATHER

Leo Wardell

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Maud Tempest

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Maud Tempest

(Address)

Payson

15.

Filed

15

1922

J. K. Jones

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 15 1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1922, to Aug 15 1922.

that I last saw h. alive on \_\_\_\_\_ 191\_\_\_\_.

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Steel Bomb

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. H. Parkhurst M. D.1922 (Address) Payson, Ida.

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payson15 1922

20. UNDERTAKER

ADDRESS

J. K. JonesPayson

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

113

FORM V. S. No. 1-19.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock  
City of Idaho FallsRegistration District No. 73Registration District No. 214-0

STATISTICS

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. S 39277Registered No. 104

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Sato

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant  
(Write the word.)

6. DATE OF BIRTH

Aug 7 1922  
(Month) (Day) (Year)

7. AGE

Still born  
Yrs. 0 Mos. 0 ds. 0IF LESS than 1 day  
how many hrs. 0  
or min. 0

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

J. S. Sato

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Hiro

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. S. Sato  
Idaho Falls

(Address)

15.

Filed

Aug 14 1922  
Idaho Falls  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 7 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to .....19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) T. C. Hollister M. D.8-7-22 (Address) Idaho Falls

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

8-7-22

20. UNDERTAKER

C. E. Dinwoodey

ADDRESS

Idaho Falls

JUL 28 1972

FEB 5 1980

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*; and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N.Y.

RECEIVED  
SEP 13 1922  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
39308  
File No. 86  
Registered No.

## 1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

## 6. DATE OF BIRTH

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

Aug. 16, 1922

1922

John H. Meyer

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month)

(Day)

(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Aug 14 1922 to Aug 18 1922  
that I last saw him alive on still for 8-11 1922  
and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH\* was as follows:

Stillborn -  
Spontaneous death - delayed transference

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

19

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH

S-89614

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

Registration District No. 117  
County of Cassia  
City of Burley  
Primary Registration District No. 2196  
St. \_\_\_\_\_File No. \_\_\_\_\_  
Registered No. 615

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Abbott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single  
(Write the word.)

## 6. DATE OF BIRTH.

Sept. 14 1922  
(Month) (Day) (Year)

## 7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day  
how many 0 hrs. or  
0 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...none  
✓

## 9. BIRTHPLACE

(State or Country)

Burley Idaho

## 10. NAME OF FATHER

L. H. Abbott

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Leining Harris

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

L. H. Abbott

(Address)

Declo Idaho

## 15.

Filed

Sept 15 1922 Dr. J. C. Patterson  
Local Registrar

## 16. DATE OF DEATH

Sept. 14 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw h... alive on Sept 14 1922  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)Prematurity

(Duration) Yrs. mos. ds.

(Signed)

9/4 1922 (Address) Burley Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ✓ yrs. ✓ mos. ✓ days In the State ✓ yrs. ✓ mos. ✓ daysWhere was disease contracted  
if not at place of death? ✓Former or  
usual residence ✓

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Declo Cemetery9/14 1922

## 20. UNDERTAKER

## ADDRESS

L. H. AbbottDeclo Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

39772  
State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 33  
Registered No. 3941

## 1. PLACE OF DEATH

County of Sanborn Registration District No. 4  
City of Pocatello Primary Registration District No. 101

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Son of P. D. Maie Clevor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Oct 18 1922  
(Month) (Day) (Year)

## 7. AGE

Still Born  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

## 9. BIRTHPLACE

(State or Country)

Pocatello

## 10. NAME OF FATHER

John Clevor

## 11. BIRTHPLACE OF FATHER

(State or Country)

Ogden Utah

## 12. MAIDEN NAME OF MOTHER

Dorcas Vane Bailey

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. V. Bailey  
Burley Route 4

## 15.

Filled

1918

22

Spring  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Oct 18 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1922 to Oct 18 1922 that I last saw him alive on Oct 18 1922 and that death occurred on the date stated above, at 3.9 M.

The CAUSE OF DEATH\* was as follows:

Respiratory failure and hemorrhage from the lungs.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

Oct 18 1922 (Address) Pocatello

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Burley Ida 10/18 1922

## 20. UNDERTAKER

## ADDRESS

M. Wacker Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

4473

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bonanza  
City of Idaho Falls

Registration District No. 73Primary Registration District No. 215-0(No. Bonanza St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Parkinson

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 89847Registered No. 167

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Nov. 31 1922  
(Month) (Day) (Year)

## 7. AGE

Born ready  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

1001

## 9. BIRTHPLACE

(State or Country)

Idaho Falls

## 10. NAME OF FATHER

Walter Parkinson

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Ada Morris

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Parkinson

(Address)

Idaho Falls

## 15.

Filed

11/23 22W. Parkinson

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Nov. 31 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Hollister

M. D.

19

(Address) Idaho Falls, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted  
if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Rose Tree Nov. 4 1922

## 20. UNDERTAKER

## ADDRESS

Jeffrey Idaho Falls

Dr. Hollister

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

NB

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH. *Bureau* Registration District No. *29*  
County of *Bureau* Primary Registration District No. *29*  
City of *Ares* STATE *Idaho* St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *S 39910*  
Registered No. *1896*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Marion H. Morgan*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*  
(Write the word.)

6. DATE OF BIRTH.

*Nov 4 1922*  
(Month) (Day) (Year)

7. AGE

*Stillborn*  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or  
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country)

*Ares, Idaho*

10. NAME OF FATHER

*James Edward Morgan*

11. BIRTHPLACE OF FATHER

(State or Country)

*Ill*

12. MAIDEN NAME OF MOTHER

*Clara L. McCall*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Wis.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*James Edward Morgan*  
*Ares, Idaho*

15.

Filed

*11/4 191 22*  
*E. J. Fox*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Nov 4 1922*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*191* to *191*  
that I last saw h. *alive* on *191*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*  
*Ateloidosis*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

*11/4 1922* (Address) *Ares, Idaho*

\*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Ares, Idaho**11/5 191 22*

20. UNDERTAKER

ADDRESS

*W. S. Sweet**Ares, Idaho*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

103



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Blaine Registration District No. 29  
City of Malad Registration District No. 2069 St.)  
**BUREAU OF VITAL STATISTICS**

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Anderson

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 39935

Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH Oct 28 1922  
(Month) (Day) (Year)

7. AGE Still Born IF LESS than 1 day  
how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Malad Ida  
(State or Country)

10. NAME OF FATHER William Anderson

11. BIRTHPLACE OF FATHER Warship Wt  
(State or Country)

12. MAIDEN NAME OF MOTHER Maud Evans

13. BIRTHPLACE OF MOTHER Malad Ida  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. H. Anderson  
(Address) Malad Ida

15. Filed Oct 29 1922 R. W. Mauer M.D.  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 28 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19  
that I last saw him alive on 19  
and that death occurred on the date stated above, at M.  
The CAUSE OF DEATH\* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Tarras M.D.

10-28-1922 (Address) Malad Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Malad Ida DATE OF BURIAL 10-28 1922

20. UNDERTAKER H. E. Johnson ADDRESS Malad

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-15

CERTIFICATE OF DEATH **S** 40079

## 1. PLACE OF DEATH

County of Lincoln  
City of Shoshone

Registration District No. ....  
Primary Registration District No. ....  
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME no Name

State of Idaho  
Board of Health  
Department of Vital Statistics  
File No. ....  
Registration No. 20  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH Sept-17  
(Month) (Day) (Year)

7. AGE 00 Yrs. 00 Mos. 00 ds.  
IF LESS than 1 day how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

none

## 9. BIRTHPLACE

(State or Country)

Shoshone Idaho

## 10. NAME OF FATHER

Leopold Beck

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Mary Myson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Louisa A. Beck

(Address)

## 15.

Filed

Sept 181922J. L. Jones

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sept-17 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Shoshone 1922

that I last saw him alive on 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stiebar

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Don't know

(Duration) Yrs. mos. ds.

(Signed)

Sept 18 1922

(Address)

[Signature]

M. D.

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Shoshone9-18 1922

## 20. UNDERTAKER

## ADDRESS

O. J. MurrianShoshone

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *New*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
JAN 6 1923  
STATISTICSRegistration District No. *2*Primary Registration District No. *1004*File No. *40272*Registered No. *288*

## 2. FULL NAME

*Infants Garrison (Still born)*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*M.*

## 4. COLOR OR RACE

*White.*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Single (Write the word.)*

## 6. DATE OF BIRTH

*Dec 16*

(Month)

(Day)

*1922*  
(Year)

## 7. AGE

Yrs.

Mos.

da.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Idaho.*

## 10. NAME OF FATHER

*Cloyd L. Garrison*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Washington.*

## 12. MAIDEN NAME OF MOTHER

*Kathryn Gregory.*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Kentucky.*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Cloyd L. Garrison*

(Address)

## 15.

Filed

*Dec 18 -**1922**R. H. Burk*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Dec 16*

(Month)

(Day)

*22*  
(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*1* 19. to 19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Acidosis from diabetes and asphymic poison of mother*

(Duration)

Yrs.

mos.

ds.

Contributory

(Secondary)

*Diabetes & Nephritis  
occurred on part of mother*

(Duration)

Yrs.

mos.

ds.

(Signed)

*C. L. Dutton*

M. D.

*Dec 17 1922*(Address) *Chelmsford Bldg. - Boise*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

days

In the

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Morris Hill Cem*

## DATE OF BURIAL

*Dec 19 1922*

## 20. UNDERTAKER

*Summers & Co.*

## ADDRESS

*Boise, Ida.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

123

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Canyon  
City of ParisRegistration District No. 3  
Primary Registration District No. 2007  
(No. .... St.)State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 40540  
Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby French

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDM | W | 5 (Write the word.)

## 6. DATE OF BIRTH

Dec 12 1922  
(Month) (Day) (Year)

## 7. AGE

Still born  
Yrs. Mos. ds. IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Canyon Co

## 10. NAME OF FATHER

John French

## 11. BIRTHPLACE OF FATHER

(State or Country) Indiana

## 12. MAIDEN NAME OF MOTHER

Vain Vandertoll

## 13. BIRTHPLACE OF MOTHER

(State or Country) Indiana

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John French

(Address)

Parma

## 15.

Filed Jan 1 1923 Shulubaldrop  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec 13 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19, to 19.that I last saw him alive on 19.and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

WM Nucklee M. D.12/15 1922 (Address) Parma

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Roswell Austin

## DATE OF BURIAL

Aug 14 1922

## 20. UNDERTAKER

Parma Fun Co

## ADDRESS

Parma

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

105



CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho  
City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. \_\_\_\_\_ St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 40585

Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Ruthenhead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child  
(Write the word.)

6. DATE OF BIRTH Dec. 22 1922  
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Moscow

10. NAME OF FATHER

Wm. C. Ruthenhead

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Lillian Lamb

13. BIRTHPLACE OF MOTHER

(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. C. Ruthenhead

(Address) Moscow, Idaho

15. Filed Dec. 22 1922 W. H. O. Ruthenhead  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 22 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at home of birth 19 22

that I last saw him alive on Dec 22 19 22  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Pneumonia with

\_\_\_\_\_ (Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. H. O. Ruthenhead M. D.

Dec 22 1922 (Address) Moscow, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

Dec 23 1922

20. UNDERTAKER

F. A. Short

ADDRESS

Moscow

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

693-203-032-364  
PLACE OF BIRTH

Form V. S. No. 11--202

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
COUNTY OF Latah  
CITY OF Shoshone  
REGISTRATION DISTRICT NO. 16 FILE NO. 59  
S 97426

No. .... St. ....  
Primary Registration District No. 104 Registered No. ....

Hospital .....  
FULL NAME OF CHILD Bess Josephine Pearl Wilson

Sex of Child Female Twin Triplet or other? and Number in order of birth 4 Legitimate? yes Date of Birth Jan 3-22  
(To be answered only in event of plural births) (Month) (Day)

FATHER  
FULL NAME Joe Wilson  
RESIDENCE Shoshone  
COLOR white AGE AT LAST BIRTHDAY 26  
(Years)  
BIRTHPLACE Idaho  
OCCUPATION R.R.

MOTHER (Todd)  
FULL MAIDEN NAME Pearl E. Brown  
RESIDENCE Shoshone  
COLOR white AGE AT LAST BIRTHDAY 23  
(Years)  
BIRTHPLACE Oregon  
OCCUPATION Wife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 4 a.m.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]  
(Physician or midwife)

Given names added from a supplemental report.

Address [Signature]  
Filed Jan 22 [Signature]  
Registrar.

MURKIN BEHEADED FOR HINDING

WAS A BIRTH RECORD FOR A FEMALE CHILD BORN IN THE CITY OF NEW YORK IN THE YEAR 1912. THE CHILD WAS BORN IN THE CITY OF NEW YORK IN THE YEAR 1912. THE CHILD WAS BORN IN THE CITY OF NEW YORK IN THE YEAR 1912.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF BIRTH

File No. *1234*

Registration District No. *1234*

Primary Registration District No. *1234*

Registered No. *1234*

Sex of Child *Female*

Full Name of Child *John Doe*

Residence *1234 5th Ave. New York City*

Color *White*

Age at Last Birthday *12* (Years)

Birthplace *New York City*

Occupation *Student*

Number of child of this mother, including present birth *1*

Number of children of this mother now living, including present *1*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *born alive or stillborn*

When there was an attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither parent nor other attendant of life after birth.

When names added from a supplemental report

Signature *John Doe*

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

JAN 17 1922

Boise, Idaho, ..... 1922

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Shoshone Idaho*  
Street .....  
County *Lincoln*

File Number 97426

Registration Dist. No. ....

Sex of Child *Female*

Date of Birth *January 3, 1922*

Father *Joseph Clark Henry Wilson*  
Full Name

Mother *Pearl Lillian Todd*  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Josephine Pearl Wilson*  
Child's Name in Full

*Joseph Clark Henry Wilson* *Pearl Lillian Todd*  
Signature of Father or Mother



son.  
son.

FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH **Lincoln** Registration District No. **16**  
 County of **Shoshone** Primary Registration District No. **1016**  
 City of **Shoshone** (St.)

File No. **36471**  
 Registered No. **20**

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Full born infant**  
**no name**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
 (Write the word.)

6. DATE OF BIRTH **Jan 3 1922**  
 (Month) (Day) (Year)

7. AGE **Born dead** IF LESS than 1 day  
 how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work **none**  
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Shoshone Idaho**  
 (State or Country)

10. NAME OF FATHER **Joe Wilson**

11. BIRTHPLACE OF FATHER **U S of A**  
 (State or Country)

12. MAIDEN NAME OF MOTHER **Rae Todd**

13. BIRTHPLACE OF MOTHER **Oregon**  
 (State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Rae Todd**  
 (Address) **Shoshone**

15. **Jan 4** 1922  
 Filed

**J. L. Brown**  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Jan 3/22** 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan 3 1922** to **Jan 3 1922**

that I last saw him alive on **Jan 3 1922** and that death occurred on the date stated above, at **4 P.M.**

The CAUSE OF DEATH\* was as follows:

**Born dead**

(Duration) Yrs. mos. ds.  
 Contributory (Secondary) **Relapsing malar**

(Duration) Yrs. mos. ds.  
 (Signed) **[Signature]** M. D.  
 (Address) **Shoshone Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Shoshone** DATE OF BURIAL **Jan 5 1922**

20. UNDERTAKER **J. L. Brown** ADDRESS **Shoshone**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 97798

County of IdahoCity of AshtonRegistration District No. 102

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 6Registered No. 95

Hospital \_\_\_\_\_

FULL NAME OF CHILD (Stillborn) Webb.Sex of Child M.Twin  
Triplet  
or other?  
(To be answered only in event of plural births)Number  
in order  
of birth  
(To be answered only in event of plural births)Legiti  
mate?Date of  
Birth1-2-22  
(Month) (Day) (Year)FULL  
NAME

FATHER

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth \_\_\_\_\_ Number of children of this mother now living, including present birth \_\_\_\_\_

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address

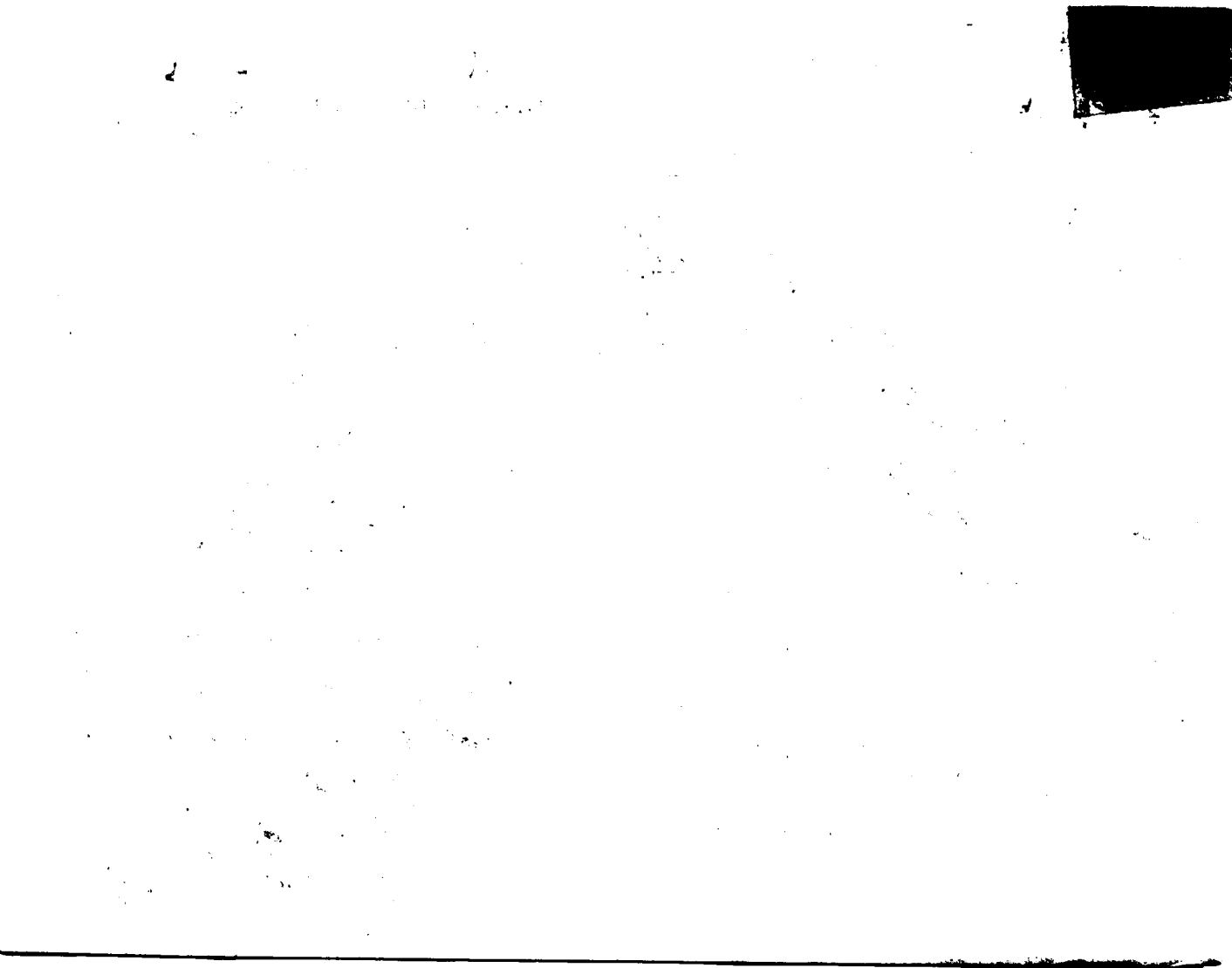
Filed

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of **Fremont**City of **Ashton**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **102**Primary Registration District No. **6**

(No.)

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **36597**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED  
FEB 6 - 1922

BUREAU OF VITAL STATISTICS

Still Born . Webb

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

**January 3 1922**  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. da.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

**Ashton Idaho**

## 10. NAME OF FATHER

**Roy Webb.**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Utah**

## 12. MAIDEN NAME OF MOTHER

**Martha M. Neeley**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Idaho**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Roy Webb**(Address) **Ashton Idaho**

## 15.

Filed **1-3-**

19

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**January 3<sup>rd</sup> 1922**  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY That I attended deceased from

**at Birth** to **Stillborn**  
that I last saw him alive on **11A** M.  
and that death occurred on the date stated above, at **11A** M.  
The CAUSE OF DEATH\* was as follows:**R.K.**

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1921 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

**Ashton Idaho 1/3/22**

## 20. UNDERTAKER

**Lewis Kiser**

## ADDRESS

**Ashton Idaho.**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

459-204-003-434  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

98127  
S

County of Bannock  
City of Idaho

RECEIVED  
FEB 8 - 1922

CERTIFICATE OF BIRTH

No. 28 St. Idaho Registration District No. 28 File No. 74  
Hospital Idaho Primary Registration District No. 2141 Registered No. 4173

FULL NAME OF CHILD

Merrill

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twins, triplet or other <u>single</u>	and {Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Jan 4</u> 192 <u>2</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? Agaoz Sol.

Number of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 5

FULL NAME F. L. Merrill  
RESIDENCE Idaho  
COLOR White AGE AT LAST BIRTHDAY 46 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Farmer

FULL MAIDEN NAME F. Belle McDonald  
RESIDENCE Idaho  
COLOR White AGE AT LAST BIRTHDAY 30 (Years)  
BIRTHPLACE Idaho  
OCCUPATION H.V.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born Stillborn Jan 4/22, 7a M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) James F. Merrill  
(Physician or midwife)

Give names added from a supplemental report.

Address Payson, Idaho  
Filed 2/1 1922 J. F. Merrill Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

THIS IS A PRELIMINARY REPORT  
 AND IS NOT TO BE USED FOR  
 ANY OTHER PURPOSE  
 WITHOUT THE WRITTEN  
 PERMISSION OF THE  
 BUREAU OF THE  
 HEALTH DEPARTMENT

DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 WASHINGTON, D. C.

**CERTIFICATE OF BIRTH**

Date of Birth _____		Place of Birth _____	
Sex _____		Race _____	
Color _____		Religion _____	
Name of Child _____		Name of Mother _____	
Name of Father _____		Name of Mother _____	
Residence _____		Residence _____	
Birthplace _____		Birthplace _____	
Occupation _____		Occupation _____	
Name of Attending Physician _____			
Signature of Registrar _____			
Date of Registration _____			

859-127-005-281  
PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-25m-9-8-15

County of Bennett

City of St. Maries

No. \_\_\_\_\_ St.

Hospital St. Maries

FULL NAME OF CHILD

REC'D

FEB 22 1922

Registration District No. \_\_\_\_\_

STA

Primary Registration District No. 1049

CERTIFICATE OF BIRTH

S 98194

File No. \_\_\_\_\_

Registered No. 2

Samuel Henry Hermann

Sex of Child Male Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legitimate? Yes Date of Birth Jan 27 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Henry Hermann

RESIDENCE St. Maries

COLOR White AGE AT LAST BIRTHDAY 38  
(Years)

BIRTHPLACE Wis.

OCCUPATION BB Man

MOTHER  
FULL MAIDEN NAME Melissa Shackelford

RESIDENCE St. Maries

COLOR White AGE AT LAST BIRTHDAY 35  
(Years)

BIRTHPLACE Ken.

OCCUPATION Housewife

Number of child of this mother, including present birth 2

Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 2:50 a.m.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

C. A. Robins  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address

St. Maries

Filed

Jan 27 1922

H. E. Smith

WRITE PLAINLY WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

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RECORDS  
BINDER



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 32

File No. 36739

County of Benewah

Primary Registration District No. 2049

Registered No. 7

City of St. Maries

FEB 27 1922

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Reinold Henry Hermann*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male* *White**Single*  
(Write the word.)

## 6. DATE OF BIRTH

*Jan* *27* *1922*  
(Month) (Day) (Year)

## 7. AGE

*Stillborn*  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)*Infant.*

## 9. BIRTHPLACE

(State or Country)

*St. Maries*

## 10. NAME OF FATHER

*Henry Hermann*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Wis.*

## 12. MAIDEN NAME OF MOTHER

*Melissa Shackelford*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Ken.*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Henry Hermann*

(Address)

*St. Maries*

## 15.

Filed *Jan 28* *1922**H. E. Hunt*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 13. DATE OF DEATH

*Jan* *27* *1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, that I attended deceased from

*Jan 27* *1922* to *Jan 27* *1922*  
that I last saw him *Stillborn* *19*  
and that death occurred on the date stated above, at *—* M.

The CAUSE OF DEATH\* was as follows:

*Nephritis and Hypertension in mother*(Duration) *unknown* mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*C. A. Robin* M. D.*1/27/1922* (Address) *St. Maries, Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Woodlawn*

## DATE OF BURIAL

*1-28* *1922*

## 20. UNDERTAKER

*H. E. Hunt Co.*

## ADDRESS

*St. Maries*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

189 K  
**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

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WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

866-231-006-866  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S98217

County of Bingham  
City of Aberdeen

No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 116 File No. 13  
Hospital \_\_\_\_\_ Primary Registration District No. 2195 Registered No. 693

FULL NAME OF CHILD

Still born (Hofer)

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>-</u>	and	Number in order of birth <u>-</u>	Legiti- mate? <u>no</u>	Date of birth. <u>Jan 31</u> 192 <u>2</u> (Month) (Day) (Year)
----------------------------	---------------------------------------	-----	---	----------------------------	--

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 0

FULL  
NAME FATHER

FULL  
MAIDEN  
NAME MOTHER Anna Hofer

RESIDENCE

RESIDENCE Aberdeen Id

COLOR

AGE AT LAST  
BIRTHDAY (Years)

COLOR White

AGE AT LAST  
BIRTHDAY (Years) 18

BIRTHPLACE

BIRTHPLACE Idaho

OCCUPATION

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 5 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

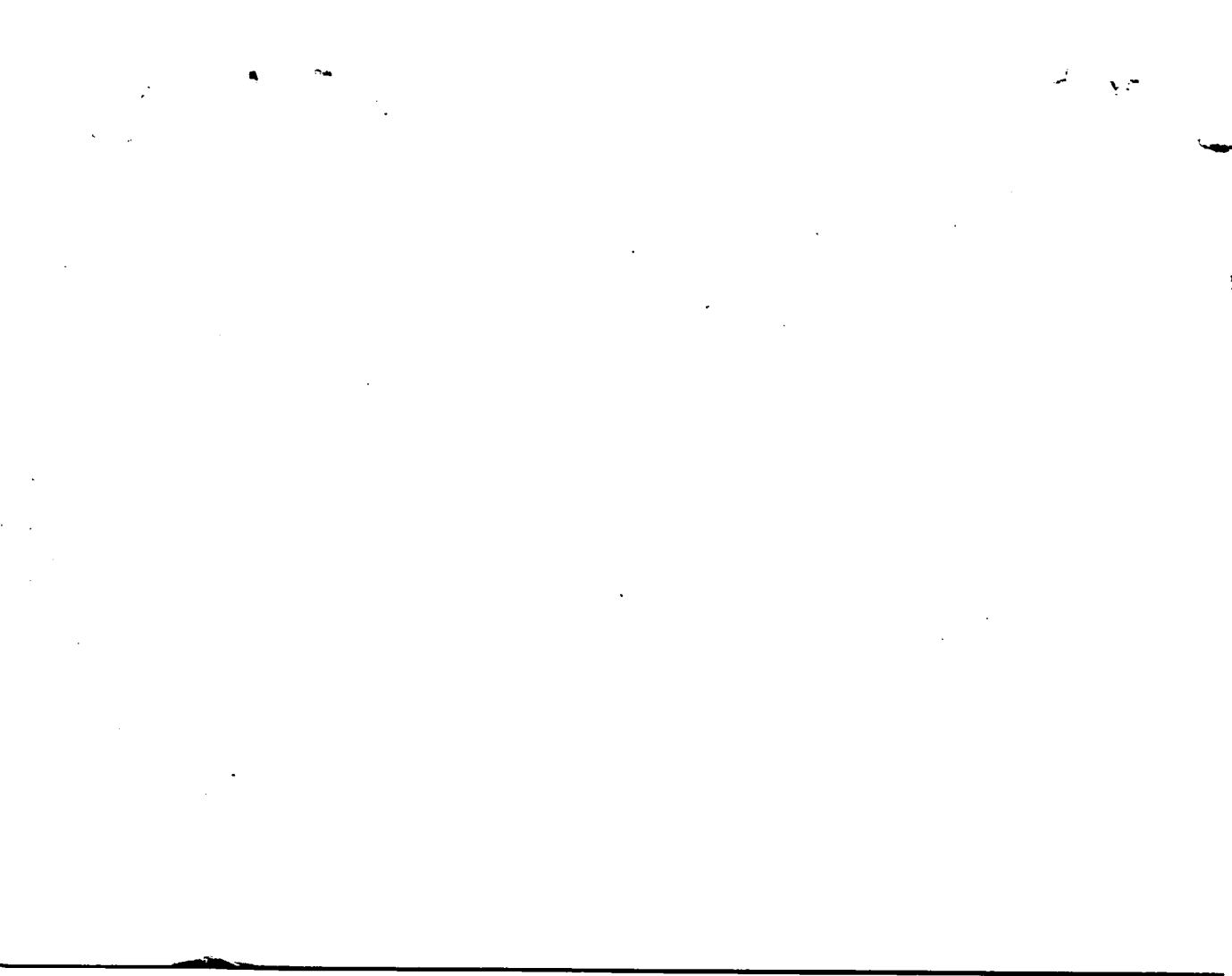
(Signature) M. C. Kinn

(Physician or midwife)

Give names added from a supplemental report.

Address Aberdeen Id

Filed Jan 31 1922 M. C. Kinn  
Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bingham  
 City of Aberdeen

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Unnamed Infant Hofer

Registration District No. 116Primary Registration District No. 2185

(No. \_\_\_\_\_ St.)

State of Idaho  
 BOARD OF HEALTH  
 -Bureau of Vital Statistics  
 File No. 38773  
 Registered No. 66

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
 (Write the word.)

6. DATE OF BIRTH January 31 1922  
 (Month) (Day) (Year)

7. AGE Still born Mos. ds. IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

8. OCCUPATION None  
 (a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Aberdeen, Idaho  
 (State or Country)

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER Unknown  
 (State or Country)

12. MAIDEN NAME OF MOTHER Anna Hofer

13. BIRTHPLACE OF MOTHER Idaho  
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Anna Hofer  
Aberdeen, Ida  
 (Address)

15. Feb 4 22 Incineration  
 Filed 19 \_\_\_\_\_ Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

January 31 1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I investigated  
19 to 19

that I last saw h. alive on 19  
 and that death occurred on the date stated above, at \_\_\_\_\_ M.  
 The CAUSE OF DEATH\* was as follows:

Still born

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory  
 (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) E. L. Egli Coroner

2/4 1922 (Address) Blackfoot, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL 9007 Cemetery Aberdeen DATE OF BURIAL Feb 4 1922

20. UNDERTAKER R N Lenthwaite ADDRESS Aberdeen, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

873-204-010-269

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

S 98331

County of BonnevilleCity of Idaho Falls, IdahoRegistration District No. 73

File No.

No. \_\_\_\_\_ St.

Primary Registration District No. 2110Registered No. 2

Hospital \_\_\_\_\_

## FULL NAME OF CHILD

Sex of Child

FemaleTwin  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legitimate?

yes

Date of Birth

Jan 4

(Month) (Day)

1922  
(Year)

FULL NAME

John Hill

FATHER

FULL MAIDEN NAME

Stella Foren

MOTHER

RESIDENCE

Idaho Falls, Idaho

RESIDENCE

Idaho Falls, Idaho

COLOR

white

AGE AT LAST BIRTHDAY

38  
(Years)

COLOR

white

AGE AT LAST BIRTHDAY

97  
(Years)

BIRTHPLACE

Germany

BIRTHPLACE

Russia

OCCUPATION

Cook

OCCUPATION

HousewifeNumber of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 11 A. M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Alfred Lewis

(Physician or midwife)

Physician

Given names added from a supplemental report.

19

Address

Idaho Falls, Idaho

Filed

11/61922W. J. Smith

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

ANYONE REPORTED FOR MISSING

RECORDED  
INDEXED  
SERIALIZED  
FILED  
JUN 10 1964  
FBI - NEW YORK

Name of Child		Date of Birth		Sex	
John Doe		12/15/63		Male	
Home Address		Registered		Primary Registration District No.	
123 Main St		12345		12345	
Last Name		First Name		Middle Name	
Doe		John		Doe	
Date of Birth		Sex		Place of Birth	
12/15/63		Male		New York	
Race		Color		Birthplace	
White		White		New York	
Occupation		Age at Last Birthday		Residence	
Student		10		123 Main St	
Number of Child of this Mother		Number of Children of this Mother now Living		Number of Children of this Mother now Deceased	
1		1		0	
Name of Attending Physician or Midwife		Signature of Mother		Signature of Father	
Dr. Smith		John Doe		Jane Doe	
Date of Birth		Date of Signature		Date of Signature	
12/15/63		12/15/63		12/15/63	
Signature of Mother		Signature of Father		Signature of Physician	
John Doe		Jane Doe		Dr. Smith	
Date of Signature		Date of Signature		Date of Signature	
12/15/63		12/15/63		12/15/63	



# DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho,.....**MAR. 7. 1922**.....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

---

Place of Birth { <div style="display: inline-block; vertical-align: middle; margin-left: 5px;">                     City .....                      Street .....                      County .....                 </div>	File Number ..... <b>98331</b> .....  Registration Dist. No. ....  Date of Birth .....192...
Sex of Child..... <b>Female</b> .....	
Father ..... <div style="text-align: center;">Full Name</div>	Mother ..... <div style="text-align: center;">Full Maiden Name</div>

I HEREBY CERTIFY that the child described herein has been named:

.....  
 Child's Name in Full

.....  
 Signature of Father or Mother

*Returned*

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

994-220-014-455

Form V. B. No. 11-25m-1-1-13

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of

City of

Registration District No.

File No.

No.

St.

Primary Registration District No.

Registered No.

Hospital

FULL NAME OF CHILD

Sex of Child

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and  
Number  
in order  
of birth

Legiti-  
mate?

Date of Birth

(Month) (Day) (Year)

FULL NAME

FATHER

FULL MAIDEN NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

(Years)

COLOR

AGE AT LAST BIRTHDAY

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given name added from a supplemental report.

(Signature)

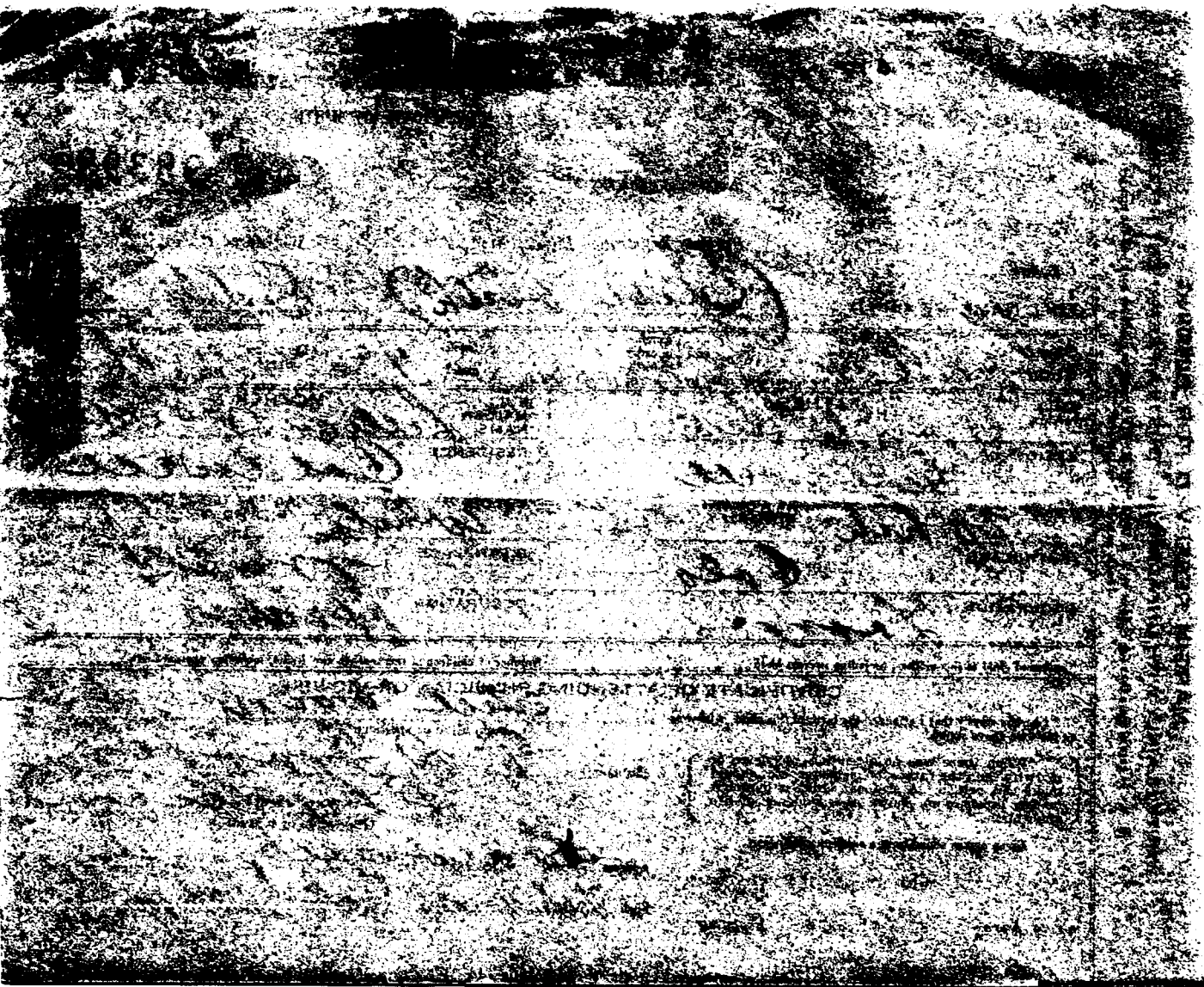
(Physician or midwife)

Address

Filed

Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **36831**  
Registered No. **10**

1. PLACE OF DEATH  
County of **Canyon**  
City of **Caldwell**  
Registration District No. **3**  
Primary Registration District No. **1005**  
(No. ) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

**Stiebbach**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**  
(Write the word.)

6. DATE OF BIRTH  
**Jan 20 1922**  
(Month) (Day) (Year)

7. AGE  
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE  
(State or Country) **Caldwell Ida**

10. NAME OF FATHER **A. E. Rider**

11. BIRTHPLACE OF FATHER  
(State or Country) **Colorado**

12. MAIDEN NAME OF MOTHER **Lillian Devertaux**

13. BIRTHPLACE OF MOTHER  
(State or Country) **Washington**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **H. H. Casman**  
(Address) **Caldwell, Ida**

15. Filed **Jan 20 1922** **John B. Meyers**  
Local Registrar

16. DATE OF DEATH  
**Jan 20 1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan 20 1922** to **Jan 20 1922** that I last saw h.e. alive on **Jan 20 1922** and that death occurred on the date stated above, at **3:30 AM**.

The CAUSE OF DEATH\* was as follows:  
**Still born**  
**Cause do not know.**  
(Duration) Yrs. **7** mos. ds.

Contributory (Secondary)  
(Duration) Yrs. mos. ds.  
(Signed) **T. D. Porter** M. D.  
1/20/22 (Address) **Caldwell, Ida**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Canyon Hill** DATE OF BURIAL **1-20-1922**

20. UNDERTAKER **CASE FURNITURE CO.** ADDRESS **Caldwell**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

666-204-001-242  
STATE OF IDAHO

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Ada

City of Boise

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District 3

File No. \_\_\_\_\_

Hospital St. Alphonsus

Primary Registration District No. 2005

Registered No. 25

FULL NAME OF CHILD

Child died at birth & not named.

(Certificate of no value without full name of child.)

Sex of  
Child

M.

Twin  
Triplet  
or other?

1 and

Number  
in order  
of birth

1

Legiti-  
mate?

Yes

Date of  
birth

2/4

1922

(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FULL  
NAME

FATHER

Harold Foote

RESIDENCE

Middleton Id

COLOR

W.

AGE AT LAST

33

BIRTHDAY (Years)

BIRTHPLACE

Middleton Id

OCCUPATION

Farmer

FULL  
MAIDEN  
NAME

MOTHER

Marguerite Bush

RESIDENCE

Middleton Id

COLOR

W.

AGE AT LAST

27

BIRTHDAY (Years)

BIRTHPLACE

Id

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 7 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

J. E. Mc

(Physician or midwife)

Give names added from a supplemental report.

Address

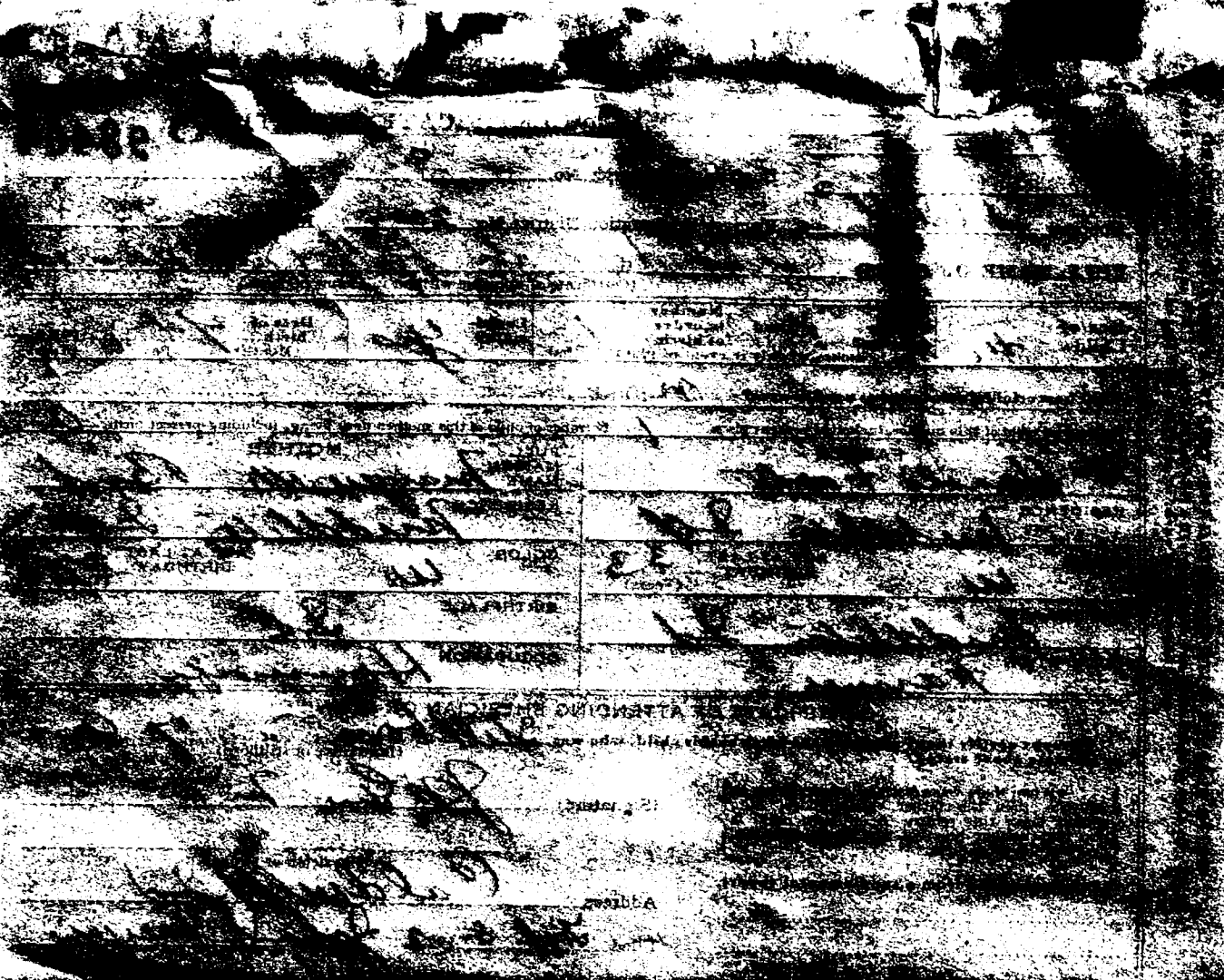
Caldwell Id

Filed

Feb. 8-1922 John V. Meyer

Registrar.

Registrar.





The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Sex of Child.....Female.....

Father Harold Edwin Foote  
Full Name

Mother Marguerite Bush Foote  
Full Maiden Name

**I HEREBY CERTIFY** that the child described herein has been named:

The child died at birth and was not named

Mrs. X. C. Tate  
Signature of Father or Mother

**OVER**

BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Ada Registration District No. 1022City of Boise Primary Registration District No. 1022

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant FrootFile No. 36694Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

M

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Feb - 4 - 1922  
(Month) (Day) (Year)

## 7. AGE

Yrs. 1 Mos. 0 ds. 0IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Boise Idaho

## 10. NAME OF FATHER

Harold Froot

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Margaret O Bush

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A J Bush  
1515 W Jefferson Boise

## 15.

Filed 2-6 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb 4  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Feb 4 1922 to Feb. 24 1922that I last saw him alive on 19and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH\* was as follows:

Still born(Duration) Yrs. mos. ds.Contributory  
(Secondary)(Duration) Yrs. mos. ds.

(Signed)

M. D.

2/5 1922 (Address) Caldwell Id

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Boise Morris Hill Cemetery Feb 4 1922

## 20. UNDERTAKER

## ADDRESS

Thurman & Trets Boise Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

419-221.0245

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

County of Gooding

City of Gooding

Registration District No. 24

File No.

**S**  
**98531**

No. \_\_\_\_\_ St.

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Gieda Birthmarum

Sex of Child girl

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and { Number  
in order  
of birth

Legiti  
mate? yes

Date of  
Birth

Jan 21 1922  
(Month) (Day) (Year)

FULL  
NAME

FATHER  
7 Y marum

RESIDENCE

Gooding

COLOR

white

AGE AT LAST  
BIRTHDAY

63  
(Years)

BIRTHPLACE

Ind

OCCUPATION

Nurseryman

FULL  
MAIDEN  
NAME

MOTHER  
Elsie Van Keuren

RESIDENCE

Gooding

COLOR

white

AGE AT LAST  
BIRTHDAY

44  
(Years)

BIRTHPLACE

Mich

OCCUPATION

Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 2 A M.  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

F. J. Cay, M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Gooding Idaho

Filed

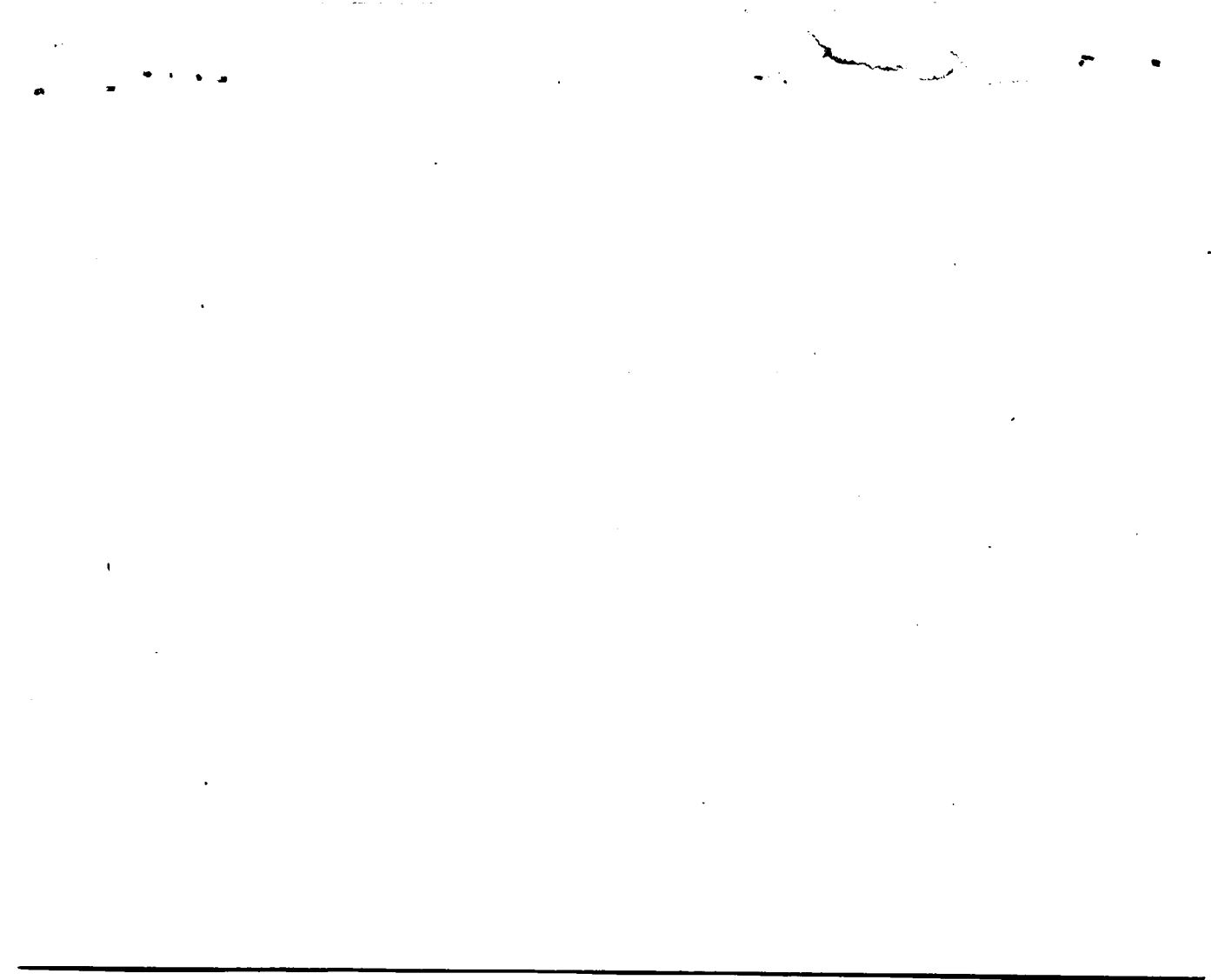
1-21-22

1922

F. J. Cay, M.D.

Registrar

Registrar



222  
VITAL  
STATISTICS

# STATE OF IDAHO

## DEPARTMENT OF PUBLIC WELFARE

MAR 7 - 1922

Boise, Idaho, .....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City ..... GOODING,  
Street ..... Washington L,  
County ..... GOODING, Idaho.

File Number ..... 98531

Registration Dist. No. ....

Date of Birth ..... January 20 • 1922

Sex of Child ..... Female

Father ..... Thomas J. Marcum,  
Full Name

Mother ..... ELsie VanKeuren,  
Full Maiden Name

HEREBY CERTIFY that the child described herein has been named: On account of a miss-  
-carry, and the child was Dead when Born,  
Child's Name in Full

Thomas J. Marcum,  
Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME

RECEIVED  
MAR 11 19  
BUREAU OF  
STATISTICS

Birth registration is part of every child's birthright.  
It establishes legally the date of the child's birth  
and legitimacy.

It enables the Public Health Nurse to make sure the  
child has been protected from danger of blindness and other infections.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men  
are being compelled to furnish certified copies of certificates of birth  
it is important that the certificates be filed with the BUREAU OF VITAL  
STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD

Office



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **36875**  
Registered No. \_\_\_\_\_

## 1. PLACE OF DEATH.

County of Gooding  
City of Gooding

Registration District No. 24  
Primary Registration District No. \_\_\_\_\_  
(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby marcum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

white

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

## 6. DATE OF BIRTH.

Jan 21 1922  
(Month) (Day) (Year)

## 7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
how many 0 hrs. or  
0 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

J J marcum

## 11. BIRTHPLACE OF FATHER

(State or Country) Ind

## 12. MAIDEN NAME OF MOTHER

Elsie Kerner

## 13. BIRTHPLACE OF MOTHER

(State or Country) Mich

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J J marcum

(Address) Gooding Idaho

## 15.

Filed 1-21-1922

J. J. Cay, M.D.  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

1-21-1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillborn -  
Gestation 7 months -

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J J Cay, M.D. M. D.

1/21 1922 (Address) Gooding Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

Gooding

## DATE OF BURIAL

1/23 1922

## 20. UNDERTAKER

A E Thompson

## ADDRESS

Gooding

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

County of Idaho

City of Kootenai

No. .... St.

Hospital .....

FULL NAME OF CHILD .....

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-24a-8-17

**S 98581**

Registration District No. .... 10.6 .....

File No. ....

Primary Registration District No. .... 2.1.8.4 ....

Registered No. .... 2 .....

Stillbirth

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u> Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>Jan 19 1922</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

FATHER  
FULL NAME Albert Brez  
RESIDENCE Kootenai - Idaho  
COLOR White AGE AT LAST BIRTHDAY 46 (Years)  
BIRTHPLACE Missouri  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Betha Tunney  
RESIDENCE Kootenai  
COLOR White AGE AT LAST BIRTHDAY 34 (Years)  
BIRTHPLACE Kansas  
OCCUPATION Housewife

Number of child of this mother, including present birth .... 6 Number of children of this mother now living, including present birth .... 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was born alive at 10 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

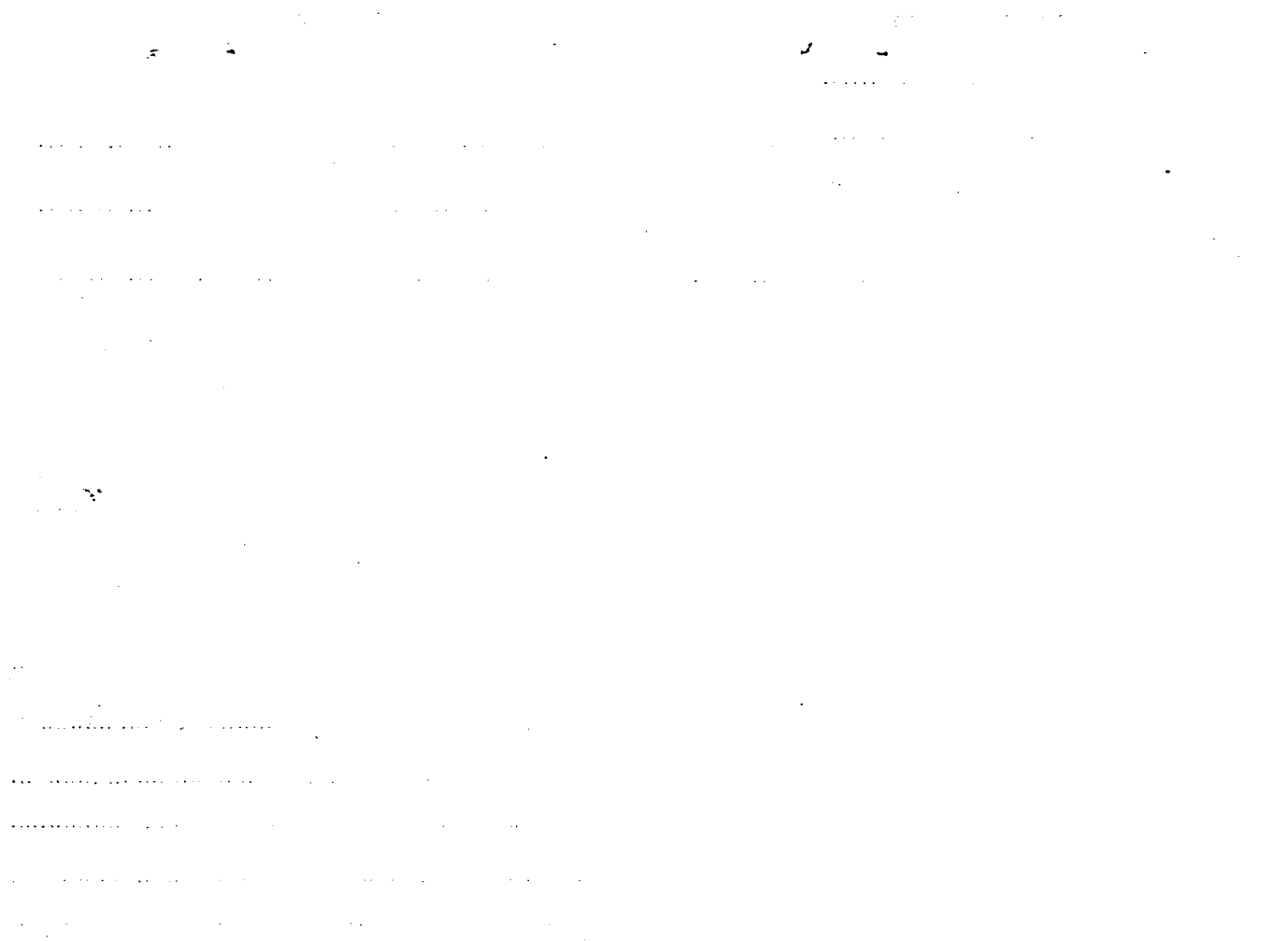
(Signature) .... J. M. Brez  
.....  
(Physician or midwife)

Given names added from a supplemental report.

Address .... Kootenai - Idaho  
Filed Feb 8 1922  
.....  
Registrar

Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

# CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 36887  
Registered No. 116

1. PLACE OF DEATH.

Registration District No. 106

County of Idaho

Primary Registration District No. 2184

City of Kootenai

(No. 1) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillbirth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single  
(Write the word.)

6. DATE OF BIRTH

Jan 19 1922  
(Month) (Day) (Year)

7. AGE

\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

IF LESS than 1 day  
how many \_\_\_\_\_ hrs. or  
\_\_\_\_\_ mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Albert Breeze

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Berta J. J. J.

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Breeze

(Address)

Kootenai

15.

Filed

Jan 20

1922

J. M. W. W.  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 19 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to 191.,

that I last saw h. alive on 191.,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Premature birth 8 mos. 19  
Hemorrhage caused by  
uterine fibroid

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. W. W. M. D.  
Jan 19 1922 (Address) Kootenai - Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Home Ridge

Jan 20 1922

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

681-124.027-681

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-3-37

## CERTIFICATE OF BIRTH

S 98641

County of *Jerome*City of *Jerome*Registration District No. *23*

File No. ....

No. .... St. *1017*Primary Registration District No. *2A.1.1*

Registered No. ....

Hospital .....

FULL NAME OF CHILD *unnamed O'Harra*

Sex of Child <i>M</i>	Twin Triplet or other? <i>-</i> and (Number in order of birth) <i>-</i>	Legitimate? <i>yes</i>	Date of Birth <i>Jan 24 1922</i> (Month) (Day) (Year)
-----------------------	---	------------------------	--

FULL NAME <i>Wheeler O'Harra</i>	FATHER	FULL MAIDEN NAME <i>Fannie O'Harra</i>	MOTHER
RESIDENCE <i>Jerome Idaho</i>		RESIDENCE <i>Jerome Idaho</i>	
COLOR <i>white</i>	AGE AT LAST BIRTHDAY <i>45</i> (Years)	COLOR <i>white</i>	AGE AT LAST BIRTHDAY <i>46</i> (Years)
BIRTHPLACE <i>Wisconsin</i>		BIRTHPLACE <i>Iowa</i>	
OCCUPATION <i>Farmer</i>		OCCUPATION <i>House wife</i>	

Number of child of this mother, including present birth ..... Number of children of this mother now living, including present birth ..... *6*

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

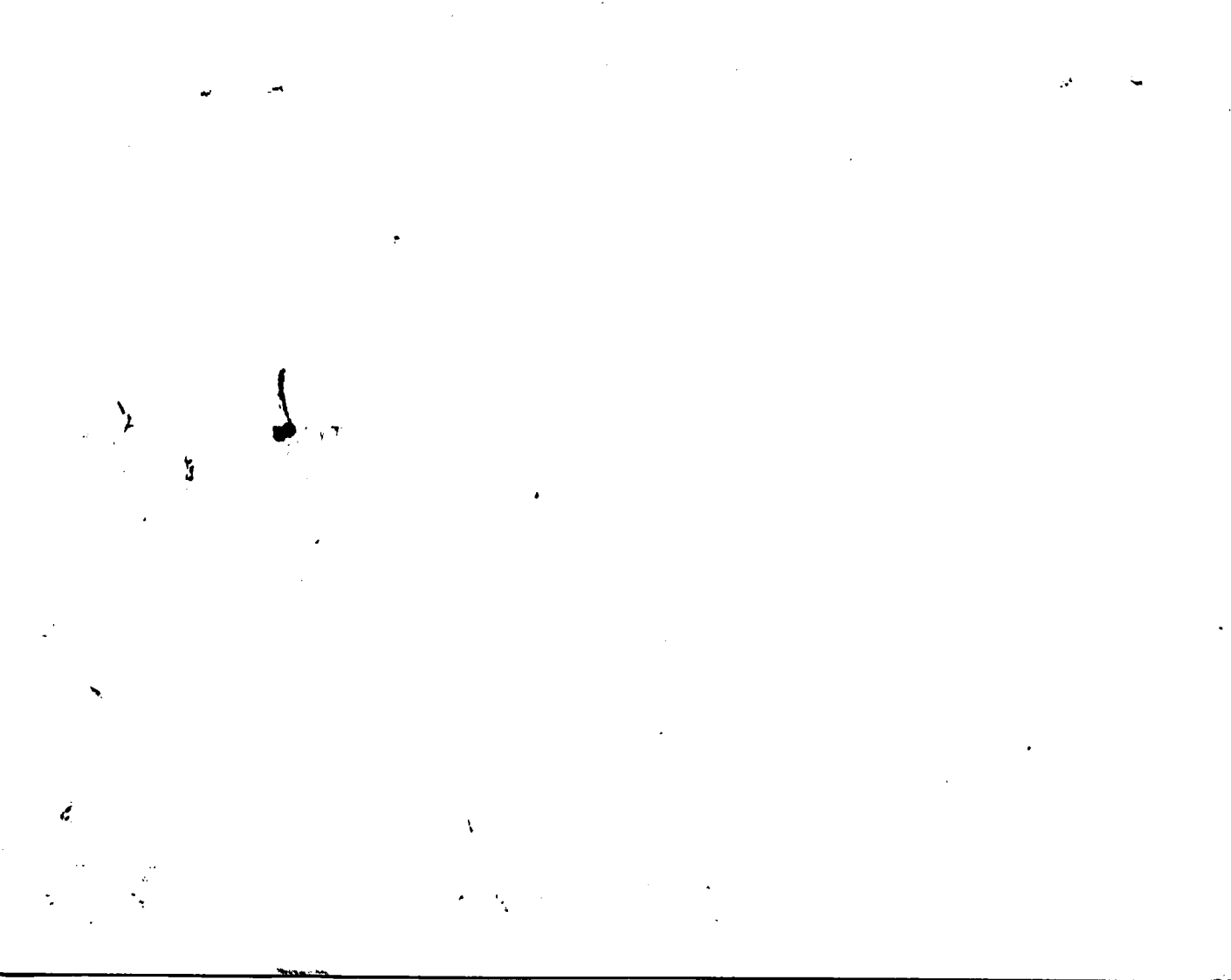
I hereby certify that I attended the birth of this child, who was *still born* at *2 P.* M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *E. D. Piper M.D.**Jerome Ida*  
(Physician or midwife)

Given names added from a supplemental report.

Address .....  
 Filed *Feb 7 1922* *E. D. Piper M.D.*  
 Registrar Registrar





WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. **RECEIVED** Registration District No. 23  
County of Jerome Primary Registration District No. 1017-2017  
City of Jerome (No. \_\_\_\_\_ St.)  
If death occurs away from usual residence, give facts called for under special information.

File No. 36908  
Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME unnamed

W. H. Barra

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant  
(Write the word.)

6. DATE OF BIRTH.

Jan 24 1922  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many \_\_\_\_\_ hrs. or  
\_\_\_\_\_ Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds.  
\_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Jerome Idaho

10. NAME OF FATHER

Wheeler Barra

11. BIRTHPLACE OF FATHER

(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER

Fannie Borden

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Barra

(Address) Jerome Idaho

15.

Filed Feb 7 1922 E. D. Piper M.D.

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922 to Jan 24 1922  
that I last saw h. alive on 1922

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH\* was as follows:

Still Born

\_\_\_\_\_ (Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

19. (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Home Farm Feb 7 1922

20. UNDERTAKER (Father) ADDRESS

Wheeler Barra Jerome Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

214-131.028-392

PLACE OF BIRTH

RECEIVED

FEB 6 - 1922

STATE BUREAU OF VITAL STATISTICS

C-25m-1-1-18

Country of KootenaiCity of CorndaleBUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 30File No. S98669

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 1050Registered No. 1213

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Infant "Still Not Named"Sex of  
ChildMTwin  
Triplet  
or other?

{

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{

(To be answered only in event of plural births)

Legit-  
mate?YesDate of  
Birth1-211922

(Month) (Day) (Year)

FULL  
NAMEFATHER Bert Sawprow.FULL  
MAIDEN  
NAMEMOTHER Clara Liberty.

RESIDENCE

Clumme, Idaho

RESIDENCE

Clumme, Idaho

COLOR

WhiteAGE AT LAST  
BIRTHDAY42  
(Years)

COLOR

WhiteAGE AT LAST  
BIRTHDAY39  
(Years)

BIRTHPLACE

Missouri

BIRTHPLACE

Washington

OCCUPATION

Farmer

OCCUPATION

House Wife

Number of child of this mother, including present birth

8

Number of children of this mother now living, including present birth

7

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.Stillborn at 2 A. M.  
(Born alive or stillborn){  
"When there was no attending physician or  
midwife, then the father, householder, etc., should  
make this return. A stillborn child is one that  
neither breathes nor shows other evidence of life  
after birth."  
}

(Signature)

J. J. Harrington, M. D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Hooley, Idaho

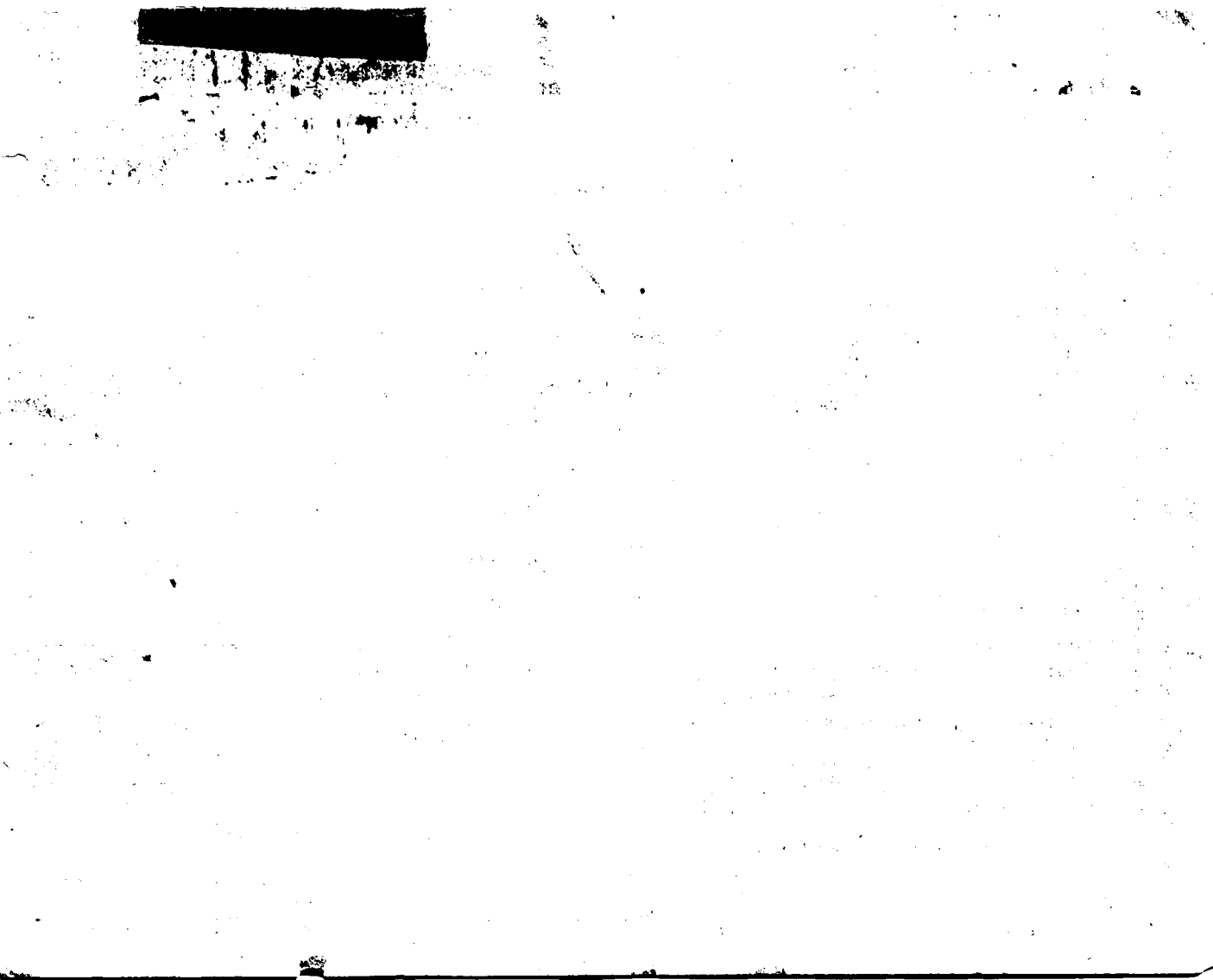
Filed

Feb 6 1922D. D. Drennon

S-Y CO. 24622

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED  
FEB 8 - 1922

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **36929**

## 1. PLACE OF DEATH.

County of *Kootenai*City of *Chamberlain*Registration District No. *30*Primary Registration District No. *1050*

(No. \_\_\_\_\_ St.)

Registered No. *1027*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Infant "Not Named"*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*M.*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

## 6. DATE OF BIRTH

*Jan 31st 1922*  
(Month) (Day) (Year)

## 7. AGE

*Stillborn*

IF LESS than 1 day  
how many ..... hrs. or  
..... mins.?

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Chamberlain Idaho.*

## 10. NAME OF FATHER

*Boat Tarpson*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Missouri*

## 12. MAIDEN NAME OF MOTHER

*Chara Liberty*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Washington*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*"Father" Tarpson,  
Chamberlain, Ida.*

## 15.

Filed

*Feb 4*

1922

*A. D. Drenne*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Jan 31st Stillborn*

(Month)

(Day)

1922 (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

191... to

191...

that I last saw him alive on 191...

and that death occurred on the date stated above, at *M.*

## The CAUSE OF DEATH\* was as follows:

*Infant Stillborn  
Mother slipped & fell on ice  
It may have caused death.*

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

*1/31 1922 (Address) *Chamberlain, Idaho.**

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days

In the State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*On Home Ranch**Jan 31st 1922*

## 20. UNDERTAKER

*None*

## ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

291-208-028-154  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Latah FEB 21 1922

City of Moscow BUREAU OF VITAL

No. 115 S. Howard St. Registration District No. 61

File No. 98719

Hospital \_\_\_\_\_ Primary Registration District No. 1011 Registered No. 10

FULL NAME OF CHILD Edna Louise Bratner

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twins Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Jan 8</u> 1922 (Month) (Day) (Year)
----------------------------	--	-------	--------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? -

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME <u>Edna Louise Bratner</u>	FATHER
RESIDENCE <u>Moscow, Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>S. Dakota</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Edna Marie Anderson</u>	MOTHER
RESIDENCE <u>Moscow, Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE <u>Sweden</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 8:30 A. M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Virgil M. Anderson  
Physician or midwife

Give names added from a supplemental report.

Address Moscow, Ida

Filed Jan 31 1922 N. H. Caruthers  
Registrar.

Registrar.

DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL RECORDS  
CITY OF CHICAGO

88319

File No.

10

Residence District No.

Registered No.

11

Primary Registration District No.

NAME OF CHILD

Sex	Color	Weight	Height	Measurements

Number of child of this mother born living and dead

MOTHER		FATHER	
NAME	NAME	NAME	NAME
RESIDENCE	RESIDENCE	RESIDENCE	RESIDENCE
COLOR	COLOR	COLOR	COLOR
BIRTHPLACE	BIRTHPLACE	BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION	OCCUPATION	OCCUPATION
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that the child of this child, was born on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_, City of Chicago, Illinois.

(Signature)

1935

RECEIVED MAY 10 1935



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH *Latah* RECEIVED  
County of *Latah* FEB 21 1922  
City of *Moscow* BUREAU OF VITAL STATISTICS  
Registration District No. *61*  
Primary Registration District No. *1011*  
City of *Moscow* (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Infant Bratmos*

File No. *36946*  
Registered No. *36946*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word.)

6. DATE OF BIRTH *Jan 8 1922*  
(Month) (Day) (Year)

7. AGE *8* IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*  
(State or Country)

10. NAME OF FATHER *Ole A. Bratmos*

11. BIRTHPLACE OF FATHER *So Dakota*  
(State or Country)

12. MAIDEN NAME OF MOTHER *Helma Andersen*

13. BIRTHPLACE OF MOTHER *Sweden*  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *O. A. Bratmos*  
(Address) *Moscow*

15. Filed *1/9* 19 *27* *M. J. Barithers*  
Local Registrar

16. DATE OF DEATH *Jan 8 1922*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
19..... to 19.....  
that I last saw him..... alive on 19.....  
and that death occurred on the date stated above, at.....M.  
The CAUSE OF DEATH\* was as follows:

*Still born*  
*Hydrocephalus*  
*by trauma of abdominal contents*  
(Duration).....Yrs.....mos.....ds.

Contributory (Secondary).....  
(Duration).....yrs.....mos.....ds.

(Signed) *Virgil M. Gilchrist* M. D.  
*1/8 1922* (Address) *Moscow, Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL *Moscow* DATE OF BURIAL *1/9 1922*

20. UNDERTAKER *W. J. Barithers* ADDRESS *Moscow*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

917-10-035-  
PLACE OF BIRTH 866

STATE OF IDAHO  
DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S98777

County of Neperce  
City of Lewiston  
No. St. Registration District No. 96 File No. S98777  
Hospital St. Joseph's Primary Registration District No. 1009 Registered No. 839  
FULL NAME OF CHILD Wm. Wayne Royon  
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twins Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth. <u>Jan 1</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	--	---------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? .....

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. None

FATHER  
FULL NAME Harold Royon  
RESIDENCE Clarkston, Wn.  
COLOR white AGE AT LAST BIRTHDAY 21 (Years)  
BIRTHPLACE Washington  
OCCUPATION Baker

MOTHER  
FULL MAIDEN NAME Bettie Hornad  
RESIDENCE Clarkston, Wn.  
COLOR white AGE AT LAST BIRTHDAY 23 (Years)  
BIRTHPLACE Nebraska  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at 6:30 P. M.  
on the date above stated. (Born live or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Paul W. Johnson

(Physician or midwife)

Address

Clarkston, Wash.

Filed

2-10-1922 Susan E. Bruce

Registrar.

Registrar.



[Faint, mostly illegible text lines, possibly bleed-through from the reverse side of the page.]

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

893.226.035-799

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

County of My PeresCity of GiffordRegistration District No. 92File No. 98806No. 1022Primary Registration District No. 2170Registered No. 40Hospital WillfordFULL NAME OF CHILD Wanda Pearl HillSex of Child FTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate?Date of  
Birth2  
(Month)26  
(Day)1922  
(Year)FULL  
NAMEFATHER Hoyle Hill

RESIDENCE

Gifford

COLOR

WhAGE AT LAST  
BIRTHDAY44  
(Years)

BIRTHPLACE

Wh. Va.

OCCUPATION

farmerFULL  
MAIDEN  
NAMEMOTHER Ella Price

RESIDENCE

Gifford

COLOR

WhAGE AT LAST  
BIRTHDAY40  
(Years)

BIRTHPLACE

Wh. Va.

OCCUPATION

housewifeNumber of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 6

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 10 a M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

E. E. Watts

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

2-261922E. E. Watts

Registrar

Registrar

1942

1942

Boise, Idaho, MAR. 7 1922 192...

Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City .....  
Street .....  
County *McKee* .....

File Number 98806 .....

Registration Dist. No. ....

Sex of Child *boy* Female .....

Date of Birth *March 26* 1922 .....

Father *Wm. Hill* Full Name .....

Mother *Ellen Friel* Full Maiden Name .....

I HEREBY CERTIFY that the child described herein has been named:

*Wilfred Hill*  
Child's Name in Full .....

*Ellen Hill*  
Signature of Father or Mother .....

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 92

37002

County of

My Peru

Primary Registration District No. 2170

City of

Bifford

St.)

File No. 5

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Heill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single

(Write the word.)

6. DATE OF BIRTH.

2

(Month)

26

(Day)

1922

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or  
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Hoyh Heill

11. BIRTHPLACE OF FATHER

(State or Country)

W. Va.

12. MAIDEN NAME OF MOTHER

Ella Price

13. BIRTHPLACE OF MOTHER

(State or Country)

W. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Hoyh Heill  
Bifford

(Address)

15.

Filed

2-26

1922

E.E. Watts

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2

(Month)

26

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. Er alive on 191

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH\* was as follows:

still born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E.E. Watts M. D.

19 (Address)

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death...yrs...mos...days In the State...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burial in Idaho

DATE OF BURIAL

2-27 1922

20. UNDERTAKER

W.E. Stoddard

ADDRESS

Bifford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

955-125-003-819

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S98997

County of Damascus

City of Postville

No. General

St.

Registration District No. 922

File No. 9

Hospital General

Primary Registration District No. 922

Registered No. 9

FULL NAME OF CHILD William Walter Penfro

(Certificate of no value without full name of child.)

Sex of Child male

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and

Number  
in order  
of birth

Legiti-  
mate? yes

Date of  
birth Jan 25

192 2

What bacteriocidal solution was used in eyes? 1% 92703

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 1

FULL  
NAME

FATHER

William Henry Penfro

FULL  
MAIDEN  
NAME

MOTHER

Vida May Harris

RESIDENCE

Large Apts. Postville Ida

RESIDENCE

Large Apts. Postville Ida

COLOR

white

AGE AT LAST  
BIRTHDAY 36

(Years)

COLOR

white

AGE AT LAST  
BIRTHDAY 27

(Years)

BIRTHPLACE

Centralia Kansas

BIRTHPLACE

Soda Springs Idaho

OCCUPATION

R.R. Conductor

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was born at Postville on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. W. Brothers

(Physician or midwife)

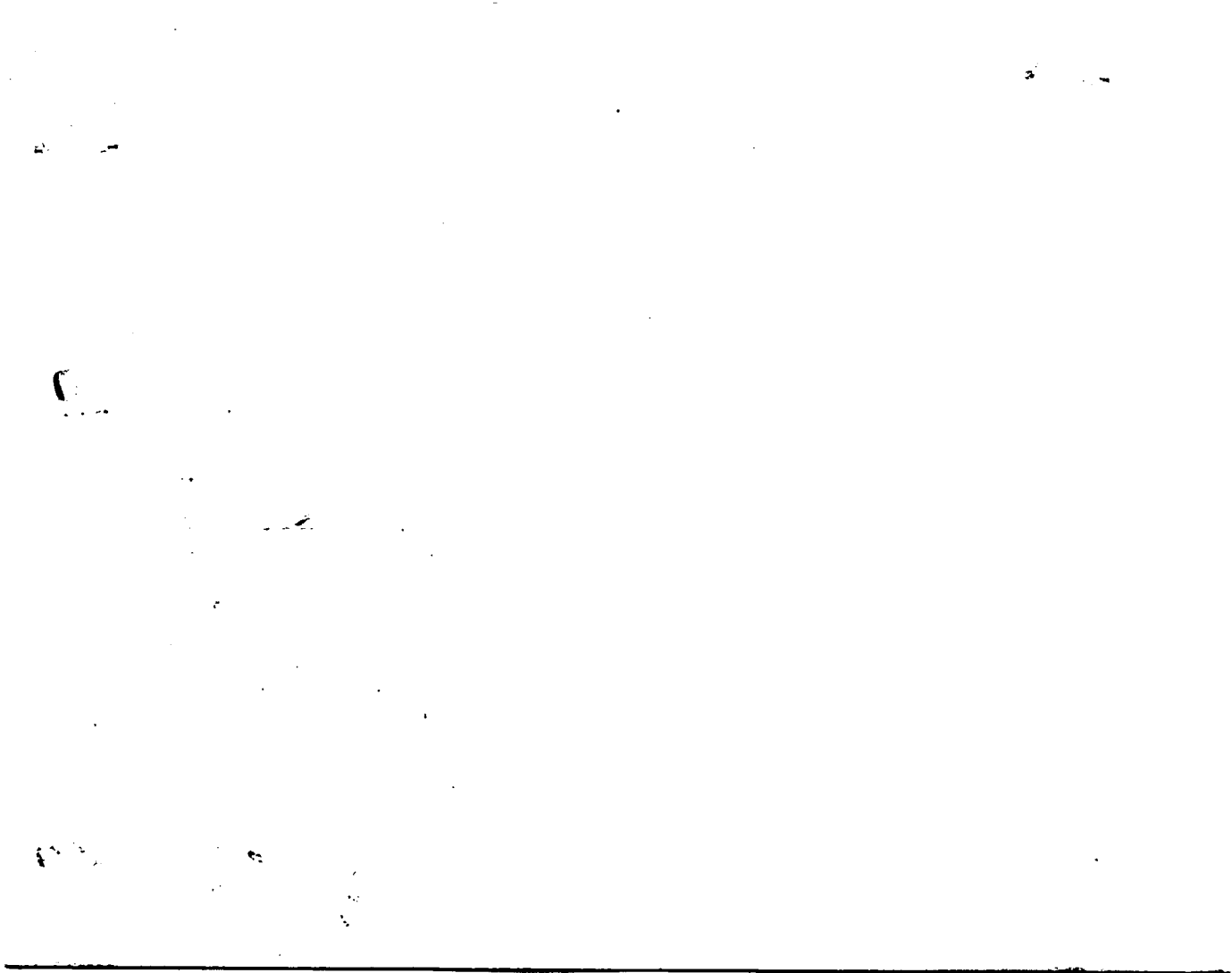
Give names added from a supplemental report.

Address Postville Idaho

Filed 31 192 2

Registrar.

Registrar.



## 1. PLACE OF DEATH

County of Barnock  
City of PocatelloRegistration District No. 28BUREAU OF VITALS  
Registration District No. 2161  
(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 38725  
Registered No. 3739

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white single (word)

## 6. DATE OF BIRTH

Jan 25 1922  
(Month) (Day) (Year)

## 7. AGE

Still born  
Yrs. Mos. ds. IF LESS than 1 day  
how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

none

## 9. BIRTHPLACE

(State or Country)

Pocatello Ida.

## 10. NAME OF FATHER

William H. Renfro.

## 11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

## 12. MAIDEN NAME OF MOTHER

Veda M. Harris

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm H. Renfro.

(Address)

Pocatello, Idaho.

## 15.

Filed

Jan 26 1922Flaming  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Jan 25 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Jan 25 1922 to Jan 25 1922  
that I last saw him alive on 19and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH\* was as follows:

Still born.

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)Relapsed cord

(Duration) yrs. mos. ds.

(Signed)

Wm Brothers M. D.1/26 1922 (Address) Pocatello, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt View Cem. Pocatello Jan 26 1922

## 20. UNDERTAKER

ADDRESS

McKee Undertaking Co. Pocatello, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife; Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

768-204003-155  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

99005

County of Bannock <sup>MAN 20 1922</sup>  
City of Pocatello <sup>BUR 5 1922</sup>  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 28 File No. 77  
Hospital General Primary Registration District No. 2161 Registered No. 4225  
FULL NAME OF CHILD Babe Payton  
(Certificate of no value without full name of child.)

Sex of Child <u>F</u>	Twin Triplet or other? _____ { and } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>2-4-1922</u> (Month) (Day) (Year)
-----------------------	---	------------------------	---

What bacteriocidal solution was used in eyes? ~~Carbolic acid~~

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FULL NAME <u>FATHER</u> <u>Henry Tietan Payton</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Lena Jensen</u>
RESIDENCE <u>Pocatello</u>	RESIDENCE <u>Pocatello</u>
COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>45</u> (Years)	COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>Kentucky</u>	BIRTHPLACE <u>Utah</u>
OCCUPATION <u>Bldg. Contractor</u>	OCCUPATION <u>Housewife</u>

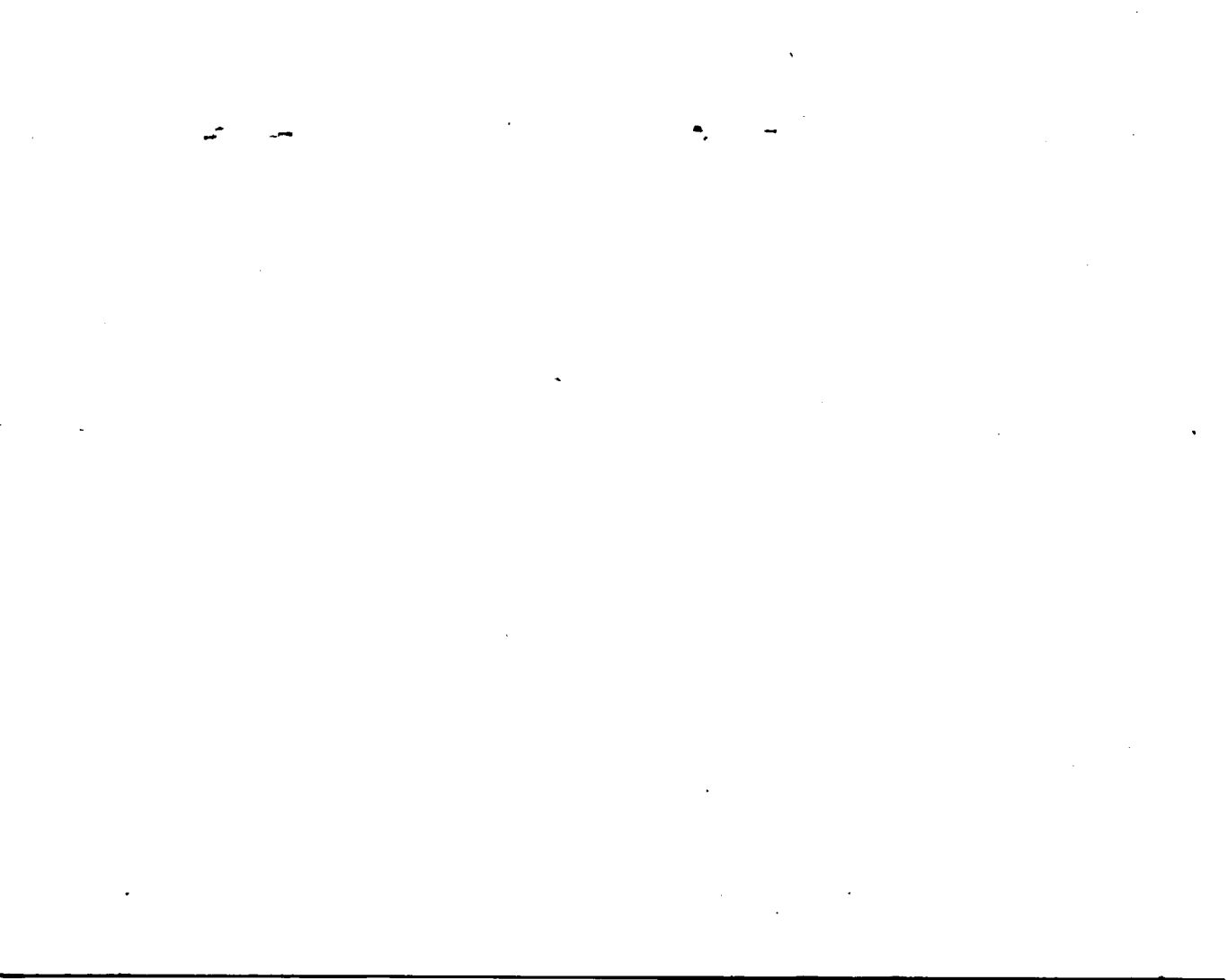
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was B. Stollow at 1 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) B. Stollow  
Physician  
(Physician or midwife)  
Pocatello  
Address \_\_\_\_\_  
Filed 3/1 1922 W. H. Young Registrar.

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_  
Registrar.





## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bannock  
City of PocatelloRegistration District No. \_\_\_\_\_  
Primary Registration District No. 2/61  
(No. General Hospital St.)State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 47  
Registered No. 3753

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Poynter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDFemale | white | Infant  
(Write the word.)

## 6. DATE OF BIRTH

February 4 1922  
(Month) (Day) (Year)

## 7. AGE

Stillborn  
Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds. \_\_\_\_\_IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)Infant

## 9. BIRTHPLACE

(State or Country)

Pocatello - Ida.

## 10. NAME OF FATHER

Henry J. Poynter

## 11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

## 12. MAIDEN NAME OF MOTHER

Lena Jensen

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Wyoming

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. J. Poynter

(Address)

Pocatello Ida.

## 15.

Filed

7/6 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

February 4 1922  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 2-4 1922 to 2-4 1922

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

J. J. Poynter M.D.2/6 1922

(Address)

Pocatello

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Mountain View Cem Feb 6 1922

## 20. UNDERTAKER

## ADDRESS

Schumacher & Hall Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

256-211-003-249  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

99038

County of Bannock  
City of Bancroft  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Hospital \_\_\_\_\_  
Registration District No. 84 File No. \_\_\_\_\_  
Primary Registration District No. 2161 Registered No. \_\_\_\_\_

FULL NAME OF CHILD Baby girl  
(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>None</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>2-11-22</u> 192 <u>2</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What bactericidal solution was used in eyes? argyrol 20%

Number of child of this mother, including present birth. 2 Number of child of this mother now living, including present birth. 1

FULL NAME <u>FATHER</u> <u>Wesley Knowles</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Catherine B Smith</u>
RESIDENCE <u>Bancroft</u>	RESIDENCE <u>Bancroft</u>
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Blackfoot Ida</u>	BIRTHPLACE <u>Logan Utah</u>
OCCUPATION <u>laborer</u>	OCCUPATION <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 4: P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

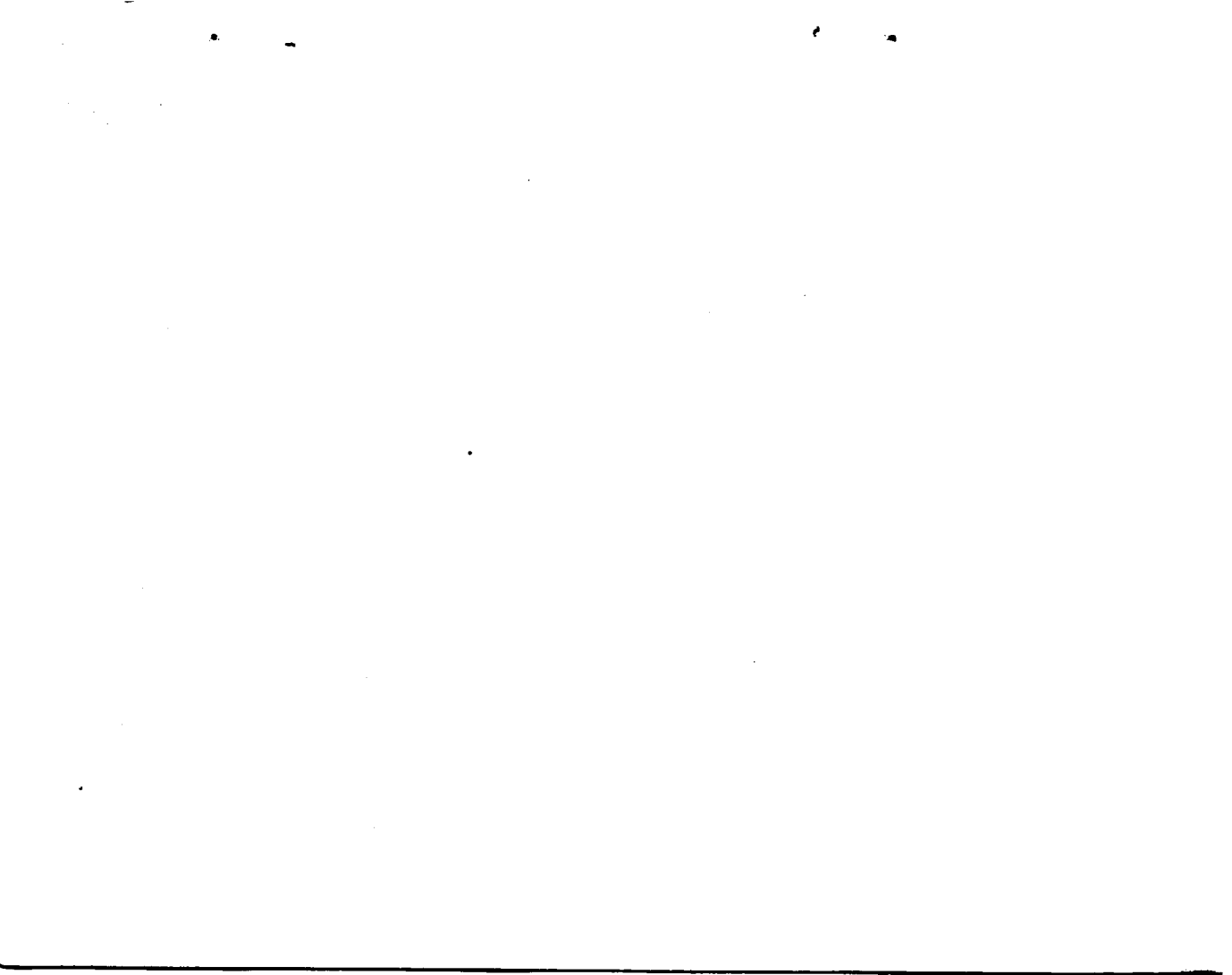
(Signature) W. S. F. Smith

M.D

(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Bancroft  
Filed 3-1 1922 W. S. F. Smith  
Registrar.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 84County of BannockPrimary Registration District No. 2161City of Bancroft

(No. ...., ..... St.)

File No. 37151  
Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Knowles

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDFW

(Write the word.)

6. DATE OF BIRTH

2-11-22

(Month)

(Day)

(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day  
how many ..... hrs.  
or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Bancroft

10. NAME OF FATHER

Wesley Knowles

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Catherine B. Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed 3-14-22 19.....Walter S. Baul  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2-11-22

(Month)

(Day)

19..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19.....

to

19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

Prolapsed cord

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) Walter S. Baul

M. D.

19..... (Address) Bancroft

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19.....

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

152-2

669-109-003 268

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of Bannock

## CERTIFICATE OF BIRTH

City of ArmoRECEIVED  
APR 5 1922  
BUREAU OF VITAL STATISTICSRegistration District No. 83File No. S 99067

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2160

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

## FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legit mate? <u>yes</u>	Date of Birth <u>Jan-9-1922</u> (Month) (Day) (Year)
--------------------------	---	-----	---	---------------------------	---

FULL NAME <u>George Worley Jr</u>	FATHER
RESIDENCE <u>Armo, Ida</u>	

FULL MAIDEN NAME <u>Marie Hopkins</u>	MOTHER
RESIDENCE <u>Switzerland Idaho</u>	

COLOR <u>red</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)
------------------	---

COLOR <u>red</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
------------------	---

BIRTHPLACE <u>Sogam Utah</u>
OCCUPATION <u>Farmer</u>

BIRTHPLACE <u>Switzerland</u>
OCCUPATION <u>Housewife</u>

Number of child of this mother, including present birth 5th Number of children of this mother now living, including present birth 4

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 1:00 A. M. on the date above stated.

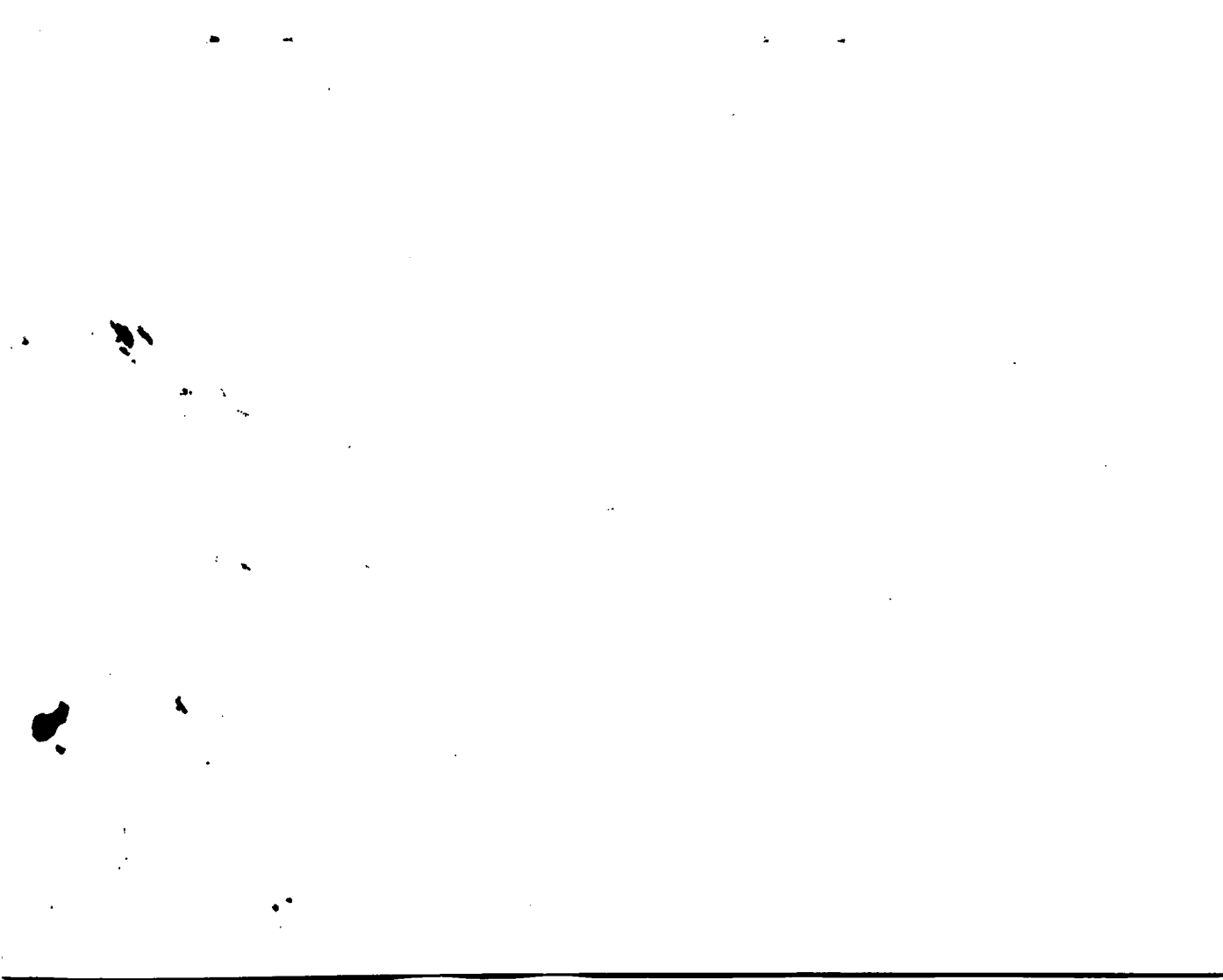
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Hartigsen  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Hawney, Idaho  
Filed Jan, 19, 1922  
Registrar J. H. Hartigsen

Registrar





## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Blaine* Registration District No. *23*  
 City of *Arino* Primary Registration District No. *2160*  
 (No. \_\_\_\_\_) (St.) \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## BUREAU OF VITAL STATISTICS

## 2. FULL NAME

*No name*

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

37118

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*  
 (Write the word.)

## 6. DATE OF BIRTH

*Jan 9 1922*  
 (Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min. ?  
 \_\_\_\_\_ Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

## 9. BIRTHPLACE

(State or Country) *Arino, Ida*

## 10. NAME OF FATHER

*George Worley, Jr.*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Egan mch*

## 12. MAIDEN NAME OF MOTHER

*maie holder*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Switzerland*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *George Worley Jr*

(Address) \_\_\_\_\_

## 15.

Filed *Jan 11 1922*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Jan 9 1922*  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 9 1922* to *Jan 9 1922*,  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_,  
 and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

*Eight and one half months  
 gestation*

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary)

*Marriage from Placenta*

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

*H. J. Hartington, M. D.*

*11-19-22* (Address) *Blaine Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Arino Idaho**1-12-1922*

## 20. UNDERTAKER

## ADDRESS

*None*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLAC

Form V. S. No. 11-25m-4-16-18

County of Bonne

013-130-208-219

City of Honolulu

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Full Name of Child

Unnamed Stillborn Nakon

SEX OF CHILD <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	Number and in order of birth	Legiti- mate? <u>yes</u>	DATE OF BIRTH <u>Mar 30 1922</u> (Month) (Day) (Year)
FULL NAME <u>Clayton Nakon</u>	FATHER		FULL MAIDEN NAME <u>Rachel Barnes</u>	MOTHER
RESIDENCE <u>Honolulu</u>			RESIDENCE <u>Nevada</u>	
COLOR <u>N</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)		COLOR <u>N</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Idaho</u>			BIRTHPLACE <u>Nevada</u>	
OCCUPATION <u>Rancher</u>			OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth... / ..... Number of children of this mother now living, including present birth 0

### CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 11 A. M. on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) A. G. Byrd, M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address Emmett Idaho  
Filed 8/3 1922 J. H. Reynolds  
Registrar

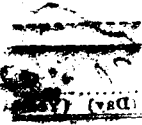
IDAHO  
STATISTICS  
Form No. 10

CERTIFICATE OF BIRTH

39124

File No.

Registered No.



DATE OF  
BIRTH

Time  
of birth

Full  
name  
at birth

Place of birth

Place of birth

Place of birth

Full Name of Child

Twins  
or other  
children  
of same  
mother

FATHER

SEX OF  
CHILD

NAME  
of  
MOTHER

RESIDENT

RESIDENT

RESIDENT

Notes: This certificate is to be filled out by the mother or the father of the child, or by the physician or the midwife who attended the birth. It should be filled out as soon as possible after the birth, and should be filed in the birth records of the county in which the child was born. This certificate is not to be used for any other purpose, and it is not to be given out to anyone except the person who filed it.

10

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

APR 5 1922

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Boise **BUREAU OF VITAL STATISTICS**  
 City of Homestead (No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

unnamed Stillborn Watson

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 37246

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male W (Write the word.)

## 6. DATE OF BIRTH

Mar 30 1922  
 (Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or 5 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Homestead, Idaho

## 10. NAME OF FATHER

Clayton Watson

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Rachel Barnes

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Nevada

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

3/31 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Mar 30 1922  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Mar 30 1922 to Mar 30 1922  
 that I last saw him alive on Mar 30 1922  
 and that death occurred on the date stated above, at 11 A, M.  
 The CAUSE OF DEATH\* was as follows:

Still born

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) A. H. Byrd M. D.

\_\_\_\_\_ 19 \_\_\_\_\_ (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

19 \_\_\_\_\_

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

759-205-04-799  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bonanza  
City of Bonner Ferry

CERTIFICATE OF BIRTH

No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 79 File No. 99179  
Hospital \_\_\_\_\_ Primary Registration District No. 2156 Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Viola Perry

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and	Number in order of birth _____	Legiti- mate? <u>Yes</u>	Date of birth. <u>Feb. 5</u> 192 <u>2</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth \_\_\_\_\_ Number of child of this mother now living, including present birth \_\_\_\_\_

FATHER  
FULL NAME Elmer Perry  
RESIDENCE Bonner Ferry, Ida.  
COLOR White AGE AT LAST BIRTHDAY 31 (Years)  
BIRTHPLACE Ido.  
OCCUPATION Locomotive Watchman

MOTHER  
FULL MAIDEN NAME Stazel Pritchard  
RESIDENCE Bonner Ferry, Ida.  
COLOR White AGE AT LAST BIRTHDAY 29 (Years)  
BIRTHPLACE Ido.  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

Stillborn

5 P.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address \_\_\_\_\_

Bonner Ferry, Ida.

Filed 2/5/1922

Registrar.

Registrar.

EVERAL REASONS

REPORTING

ON THE



Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Bonniers Ferry* .....  
Street .....  
County *Boundary* .....  
File Number ..... *99179* .....  
Registration Dist. No. ....  
Sex of Child ..... *Female* .....  
Date of Birth ..... *Febr 5* ..... 192*2*..  
Father *Wesley Elmer Perry* ..... Mother *Erma Hazel Pritchard* .....  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

..... *Viola Perry* .....  
Child's Name in Full

..... *Mrs Hazel Perry* .....  
Signature of Father or Mother

- - - - -  
Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

763-120,018-419  
PLACE OF BIRTHSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—Rev. 1-1-11

## CERTIFICATE OF BIRTH

S

County of ClearwaterCity of Elk RiverRegistration District No. 91File No. 99297

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2114

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD Gervasio SollaSex of  
Child MaleTwin  
Triplet  
or other?

—

{ and }

Number  
in order  
of birth1st

{ }

Legiti-  
mate?YesDate of  
Birth Feb. 20, 1922

(Month)

(Day)

(Year)

FULL  
NAMEAugust Solla

RESIDENCE

Elk River

COLOR

WhiteAGE AT LAST  
BIRTHDAY3.3  
(Years)

BIRTHPLACE

Italy

OCCUPATION

CarpenterFULL  
MAIDEN  
NAMEEustina Martini

RESIDENCE

Elk River

COLOR

WhiteAGE AT LAST  
BIRTHDAY2.3  
(Years)

BIRTHPLACE

Italy

OCCUPATION

HousewifeNumber of child of this mother, including present birth 1st

Number of children of this mother now living, including present birth \_\_\_\_\_

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.Still born at 7 P. M.  
(Born alive or stillborn)\*When there was no attending physician or  
midwife, then the father, householder, etc., should  
make this return. A stillborn child is one that  
neither breathes nor shows other evidence of life  
after birth.

(Signature)

Dr. F. P. McCormick

(Physician or midwife)

Given names added from a supplemental report.

19 \_\_\_\_\_

Address \_\_\_\_\_

Filed Feb. 23, 1922

1922

Mr. F. P. McCormick

DEPARTMENT OF  
THE ARMY  
WASHINGTON, D. C.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **37179**  
Registered No. **37179**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of *Bonner*  
City of *Bonner Ferry*

Registration District No. *79*  
Primary Registration District No. *3156*  
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Perry*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Female*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

## 6. DATE OF BIRTH.

*Feb. 5th 1922*  
(Month) (Day) (Year)

## 7. AGE

..... Yrs. .... Mos. .... ds.

IF LESS than 1 day  
how many .... hrs. or  
..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*Elmer Perry*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Ido.*

## 12. MAIDEN NAME OF MOTHER

*Hazel Pritchard*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Ido.*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. *2/5/22*  
Filed *2/5/22* 191*22*

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Stillborn*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
..... 191..... to ..... 191.....

that I last saw h..... alive on ..... 191.....  
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

*Difficult labor.*

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... Yrs. .... mos. .... ds.

(Signed)

*2/5/22* (Address) *Bonner Ferry, Id.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place ..... In the  
of death ..... yrs. .... mos. .... days, State ..... yrs. .... mos. .... days

Where was disease contracted  
if not at place of death?

Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Bonner Ferry, Id.*

## DATE OF BURIAL

*2/5/22*

## 20. UNDERTAKER

*Elmer Perry*

## ADDRESS

*Bonner Ferry*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia*, *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City Elk River  
 Street Box 132  
 County Idaho

File Number 99297

Registration Dist. No. ....

Sex of Child MaleDate of Birth Feb 20<sup>th</sup> 1922Father August Golla  
Full NameMother Giustina Martini  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Gervasio Golla  
 Child's Name in Full

August Golla Giustina M.  
 Signature of Father or Mother

Birth registration is part of every child's birthright.  
It establishes legally the date of the child's birth, parentage  
legitimacy.

It enables the Public Health Nurse to make sure the child has  
protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are com-  
ing to furnish certified copies of certificates of birth, it is im-  
portant that the certificates be filed with the BUREAU OF VITAL STATIS-  
tics and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

Artini



719-109-027-236

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

## CERTIFICATE OF BIRTH

S 99357

County of JeromeCity of JeromeRegistration District No. 23

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 1017

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Unmarried Parr (John Wm Parr)

Sex of Child

MTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate?yesDate of  
BirthFeb 9 22  
(Month) (Day) (Year)

(To be answered only in event of plural births)

FULL  
NAMEFrank Parr

FATHER

RESIDENCE

Jerome Ida

COLOR

whiteAGE AT LAST  
BIRTHDAY42  
(Years)

BIRTHPLACE

Ohio

OCCUPATION

LabourFULL  
MAIDEN  
NAMEPhylla Stock

MOTHER

RESIDENCE

Jerome Idaho

COLOR

whiteAGE AT LAST  
BIRTHDAY36  
(Years)

BIRTHPLACE

Indiana

OCCUPATION

House wifeNumber of child of this mother, including present birth 4Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 3:30 P.M.  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

E. D. Piper M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Jerome Idaho

Filed

Feb 10 1922E. D. Piper M.D.

Registrar

Registrar

**MAVCA RESERVES FOR RUSSIA**

...of his sister birth.  
...and that neither mother nor father ever  
...A witness could  
...homesteaded  
...When there was no attending physician to

amtbh, E

५५५

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

NOTARY PUBLIC

30A14H7910

Color

123071

## REFERENCE

NAME  
BANDEN  
RULL

ЯЗЫКОМ

only in cases of grave illness

**Healthier**

**STUDIES**

**Healthier**

**Abstract**

to state:  
that

PRINTED AT THE

NOV

City of

५१५०८)

72899

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

BUREAU

Boise, Idaho,.....

192...

Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

City ..... *Jerome, Idaho* ..... File Number ..... *99357* .....  
Street .....  
County ..... *Jerome, C. I.* .....  
Date of Birth ..... *Feb. 9* ..... 192*2* .....  
of Child ..... *Male* .....  
Full Name ..... *Frank Parr* .....  
Mother ..... *Phylla Scott* .....  
Full Maiden Name

HEREBY CERTIFY that the child described herein has been named:

..... *John William Parr* .....  
Child's Name in Full

..... *Mrs. Frank Parr* .....  
Signature of Father or Mother



SEVERAL REASONS WHY A CERTIFICATE OF BIRTH  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE

- - - - -

Birth registration is part of every child's birth.  
It establishes legally the date of the child's birth  
and legitimacy.

It enables the Public Health Nurse to make sure  
been protected from danger of blindness and other infections.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Servicemen are being  
called to furnish certified copies of certificates of birth, it is  
important that the certificates be filed with the BUREAU OF  
VITAL RECORDS and the same completed by furnishing the name of the

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR

Dea

ance  
and

Plac  
of  
Birth

Sex

Fath

I H

.....

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

## ✓ CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 23

County of

Primary Registration District No. 1017-2017

City of

(No. St.)

If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

## 2. FULL NAME

Unnamed Carr

File No. 37263

Registered No.

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

M

## 4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

Infant

(Write the word.)

## 6. DATE OF BIRTH

Feb (9) 1922

(Month)

(Day)

(Year)

## 7. AGE

Stillborn

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work  
(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)

Infant

## 9. BIRTHPLACE

(State or Country)

Jerome Idaho

10. NAME OF  
FATHER

Frank Carr

11. BIRTHPLACE  
OF FATHER

(State or Country)

Indiana Ohio

12. MAIDEN NAME  
OF MOTHER

Phylla Stock

13. BIRTHPLACE  
OF MOTHER

(State or Country)

Indiana

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Frank Carr

(Address)

Jerome Idaho

## 15.

Filed

Feb 10 1922

E. D. Spurr M.D.

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb 9 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from  
Feb 9 1922 to Feb 9 1922

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. D. Spurr M.D.

2/10 1922 (Address) Jerome Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted  
if not at place of death?

Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Jerome Cemetery

Feb 10 1922

## 20. UNDERTAKER

## ADDRESS

Frank Carr (Father)

Jerome

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

613-128,028-713  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Morven

City of Post Falls

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. \_\_\_\_\_

30

File No. \_\_\_\_\_

99368

Hospital \_\_\_\_\_

Primary Registration District No. 1057

Registered No. 1229

FULL NAME OF CHILD \_\_\_\_\_

not named Walden

(Certificate of no value without full name of child.)

Sex of Child \_\_\_\_\_

Male

Twin  
Triplet  
or other?

1, { and {

Number  
in order  
of birth

12

Legiti-  
mate?

yes

Date of  
birth

Feb. 28

1922

(Month)

(Day)

(Year)

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? \_\_\_\_\_

Argoroll

Number of child of this mother, including present birth 12

Number of child of this mother now living, including present birth 10

FULL  
NAME

FATHER

Francis Marion Walden

FULL  
MAIDEN  
NAME

MOTHER

Myrtle Viola Gale

RESIDENCE

Post Falls Ida

RESIDENCE

Post Falls Ida

COLOR

white

AGE AT LAST  
BIRTHDAY

45

(Years)

COLOR

white

AGE AT LAST  
BIRTHDAY

38

(Years)

BIRTHPLACE

Iowa

BIRTHPLACE

Miss

OCCUPATION

Farmer

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

Stillborn, at 4:10 P. M.  
(Born alive or stillborn)

\* When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Peter Reid

Physician

(Physician or midwife)

Give names added from a supplemental report.

Address

Spokane Wash

Filed

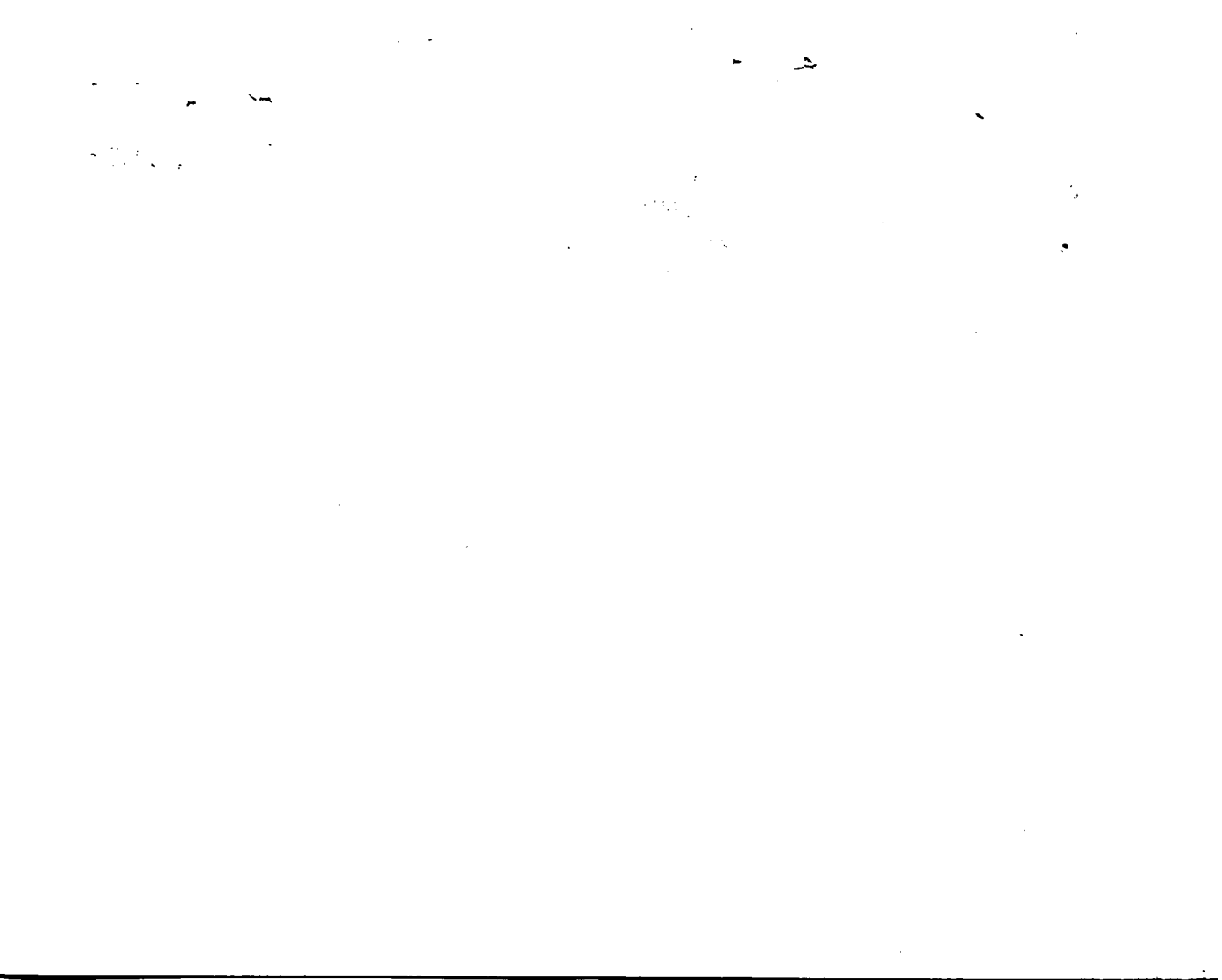
3/6

1922

H. D. Drennan

Registrar.

Registrar.





FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Kootenai*  
City of *Coeur d'Alene*Registration District No. *30*Primary Registration District No. *1037*

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Stillborn Walden*State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *37271*  
Registered No. *1032*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Single*  
(Write the word.)

## 6. DATE OF BIRTH

*Feb. 28 1922*  
(Month) (Day) (Year)

## 7. AGE

*Yrs. Mos. ds.*IF LESS than 1 day  
how many ..... hrs.  
or ..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Post Falls, Id.*

## 10. NAME OF FATHER

*Francis Marion Walden*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Iowa*

## 12. MAIDEN NAME OF MOTHER

*Myrtle Violet Gale*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*F. M. Walden*

(Address)

*Post Falls, Id.*

## 15.

Filed *3/6**1922**D. D. Druma*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Feb. 28 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*19.....*, to *19.....*

that I last saw him ..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

*Premature separation of Placenta*

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed)

*Peter Reid*

M. D.

*2/28 1922*(Address) *Spokane Wash.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Riverside Park**2/28 1922*

## 20. UNDERTAKER

## ADDRESS

*F. M. Walden Post Falls, Id.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

753-109-029-549  
PLACE OF BIRTH

County of Latah

City of (Oneway)

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Registration District No. 65

File No. 99392

Primary Registration District No. 2145

Registered No. \_\_\_\_\_

Sex of Child male Twin Triplet or other?  } and  } Number in order of birth 3 Legiti mate? yes Date of Birth Feb 7 1922  
(To be answered only in case of plural births) (Month) (Day) (Year)

FULL NAME Mike Petrogalla FATHER

RESIDENCE Latah Co. Ids

COLOR white AGE AT LAST BIRTHDAY 46  
(Years)

BIRTHPLACE Italy

OCCUPATION Baker

FULL MAIDEN NAME Agdini Muzoles MOTHER

RESIDENCE Latah Co Ids

COLOR white AGE AT LAST BIRTHDAY 45  
(Years)

BIRTHPLACE Italy

OCCUPATION Housewife

Number of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 6:30 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

19

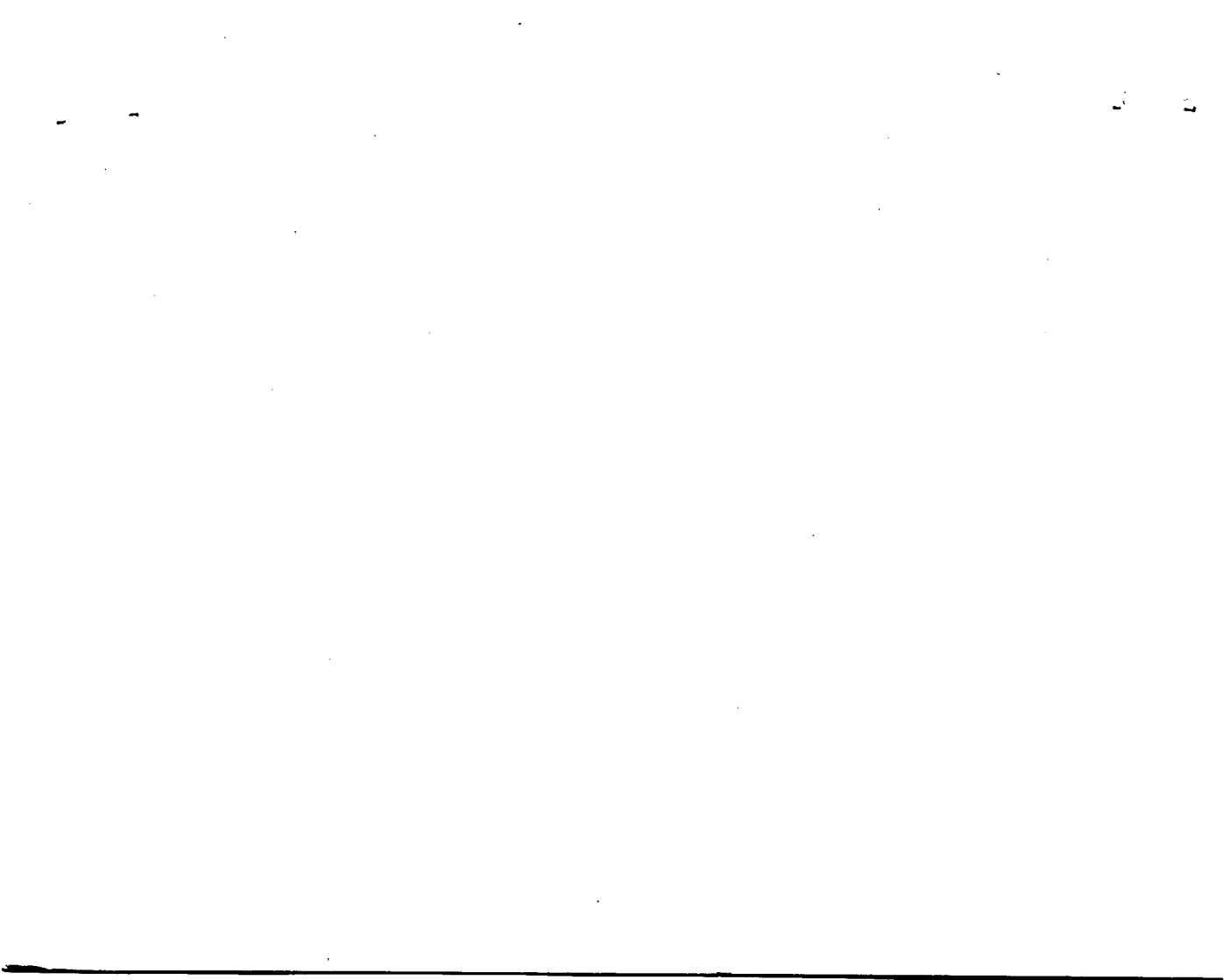
(Signature) Ernest Stein

(Physician or midwife)

Address Salmon Idaho

Filed Feb. 10 1922 D. J. Thompson  
Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

## CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No. 36320

Registered No.

1. PLACE OF DEATH.

Registration District No. 65

County of Latah

Primary Registration District No. 2145

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nizio Petrogalla

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single  
(Write the word.)

6. DATE OF BIRTH

Feb.

(Month)

7

(Day)

1922

(Year)

7. AGE

none

yrs.

mos.

ds.

IF LESS than 1 day

how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Latah Co

10. NAME OF FATHER

Mike Petrogalla

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Agelini Muzilese

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mike Petrogalla

(Address)

O'Connoray Latah Co

15.

Filed Feb. 8 1922

Dr. J. H. Thompson  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb.

(Month)

7

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

on Feb 7 -

1922, only

1922

that I last saw him alive on 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still Birth due to  
Dystocia

(Duration) yrs. mos. ds.

Contributory (Secondary)

none

(Duration) yrs. mos. ds.

(Signed)

Feb 7

Ernest S. Hens M. D.

1922 (Address) Pullman, Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Potterbury Cemetery

Feb 8 1922

20. UNDERTAKER

ADDRESS

Parents

Potterbury

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

749-210-035-236  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—25m-9-8-15

County of Myer

MAR 20 1922

CERTIFICATE OF BIRTH

City of Levinston

BUREAU OF VITAL  
STATISTICS  
Registration District No. 96

S 99469  
File No. 878

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 1009 Registered No. 878

Hospital \_\_\_\_\_

FULL NAME OF CHILD Albert L. Gurney

Sex of Child <u>F</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and (Number in order of birth) _____	Legitimate? <u>yes</u>	Date of Birth <u>2-10-22</u> (Month) (Day) (Year)
-----------------------	---	--------------------------------------	------------------------	--

FULL NAME Albert L. Gurney

FULL MAIDEN NAME Bertha Bloom

RESIDENCE Peek-Ida.

RESIDENCE Peek-Ida.

COLOR W AGE AT LAST BIRTHDAY 43  
(Years)

COLOR W AGE AT LAST BIRTHDAY 39  
(Years)

BIRTHPLACE Nebr

BIRTHPLACE Nebr

OCCUPATION Warehouseman

OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated. 10:40 P.M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) S. M. Lyle

(Physician or midwife)

Given names added from a supplemental report.

Address \_\_\_\_\_

Filed Mar 10 1922 Susan E. Bruce

Registrar

Registrar

396

22.9 - 20

... de ...

10-10-68

4 200 1974



Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City Lewiston  
Street St. Joseph Hospital  
County Nez Perce

File Number 99469

Registration Dist. No. ....

Sex of Child Female Date of Birth February 10 1922

Father Albert Lea Gurnsey Mother Bertha Alice Bloom  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Born Dead and we did not name Her

Child's Name in Full

Albert Lea Gurnsey  
Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

Birth registration is part of every child's birthright.  
It establishes legally the date of the child's birth, parentage  
and legitimacy.

It enables the Public Health Nurse to make sure the child has  
been protected from danger of blindness and other infections at birth.

- - - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - - -

1. The correct age for purposes of school attendance.

2. Employment.

3. Protection under the law.

4. Military and jury duty.

5. Right to travel unmolested in foreign lands.

6. Right to vote.

7. Right to receive pensions and inherit property.

8. Furnishes acceptable evidence of genealogy.

9. Right to get married.

10. Just at this time while many of the Ex-Service men are com-  
pelled to furnish certified copies of certificates of birth, it is im-

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bozeman Registration District No. 96  
 City of Lewiston Primary Registration District No. 1009  
 (No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Gurnsey

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 37305  
 Registered No. 767

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

F

## 4. COLOR OR RACE

W

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
 (Write the word.)

## 6. DATE OF BIRTH

Feb 10 1922  
 (Month) (Day) (Year)

## 7. AGE

1 Yrs. 1 Mos. 6 ds.

IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Stillborn

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Albert H. Gurnsey

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Bertha Bloom

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Ore

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Gurnsey

(Address)

Rock - Id

## 15.

Filed

Mar 10 1922

Susan E. Bruce  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb 10 1922  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19\_\_\_\_ to 19\_\_\_\_

that I last saw him alive on 19\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_ M.

The CAUSE OF DEATH was as follows:

Stillborn

(Duration) \_\_\_\_ Yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
 (Secondary)

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

J. M. Lytle

11 1922 (Address) Lewiston Id

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ days. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

## DATE OF BURIAL

Feb 11 1922

## 20. UNDERTAKER

## ADDRESS

Lewiston, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

795-125-076-386

PLACE OF BIRTH

County of O-needa

City of Malad

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Registration District No. 26

Primary Registration District No. 2064

File No. \_\_\_\_\_

Registered No. 20

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

**S**  
**99510**

Baby Pinson

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate?	Date of Birth <u>Jan 25</u> 19 <u>22</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-----------------	--

FULL NAME <u>Emory Pinson</u>	FATHER
RESIDENCE <u>Malad, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>West Va.</u>	
OCCUPATION <u>Barber</u>	

FULL MAIDEN NAME <u>Elizabeth Thomas</u>	MOTHER
RESIDENCE <u>Malad, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  
Sarah Hughes (midwife) still born, at 6 a. m.  
I hereby certify that I attended the birth of this child, who was  
on the date above stated. (Born alive or stillborn)

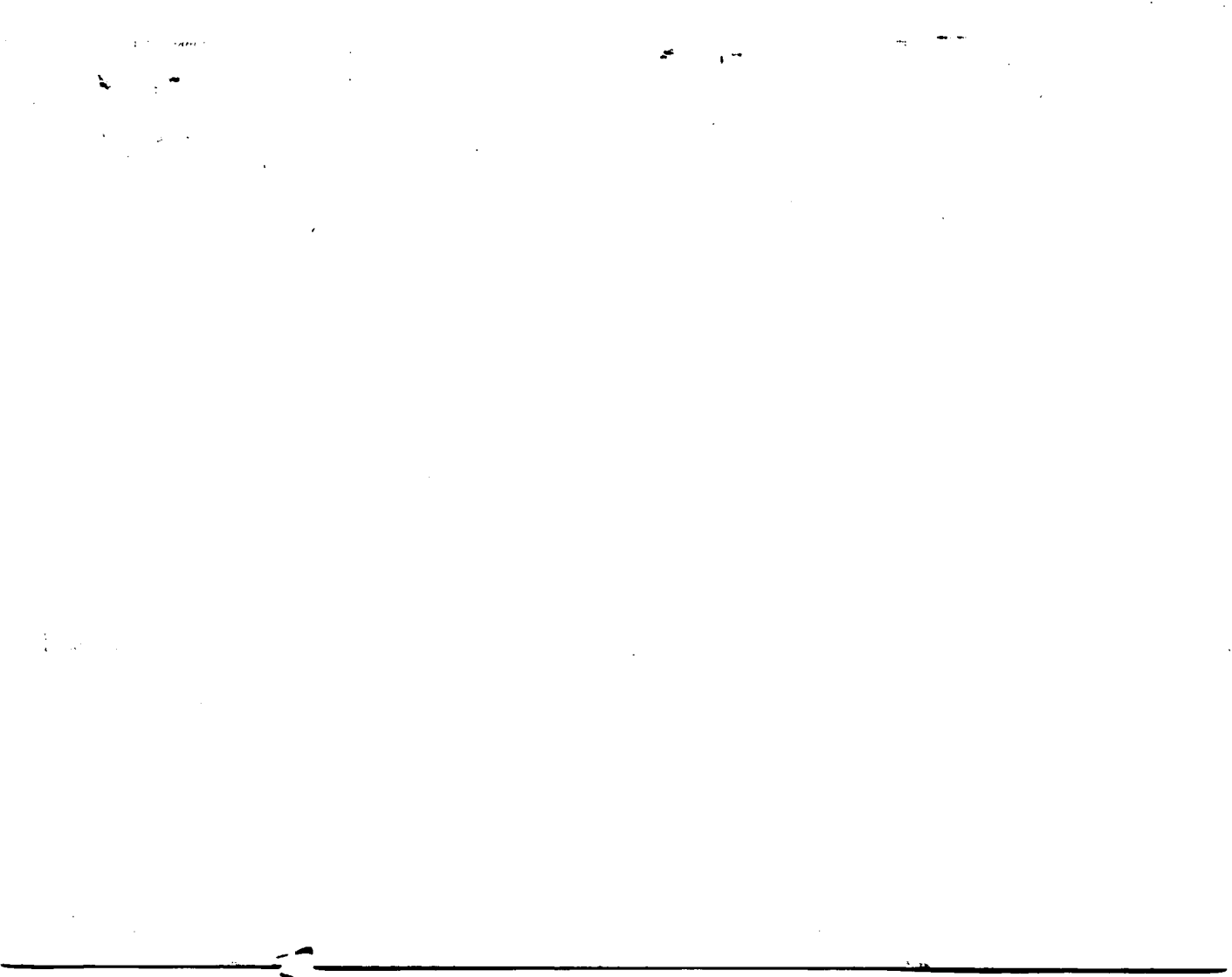
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

19 \_\_\_\_\_

Registrar

(Signature) J. T. Mauer M.D.  
Physician  
I was not present. Only one body by name of Sarah Hughes  
Address \_\_\_\_\_  
Filed Mar 6 1922 J. T. Mauer M.D.  
Registrar



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Conuda*  
City of *Malad*Registration District No. *26*Primary Registration District No. *2069*

(No. \_\_\_\_\_ St.)

File No. *37316*

Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Baby Pinion*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Child*  
(Write the word.)

## 6. DATE OF BIRTH

*Jan 25 1922*  
(Month) (Day) (Year)

## 7. AGE

*Full Born*  
Yrs. Mos. ds. IF LESS than 1 day how many hrs.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

*Malad Ida*

## 10. NAME OF FATHER

*Emery Pinion*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*West Virginia*

## 12. MAIDEN NAME OF MOTHER

*Elizabeth Thomas*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Malad Ida*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Emery Pinion Malad*

## 15.

Filed

*Feb 20 1922**R T Mauer M.D.*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Jan 25 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

*no physician present. Death caused by asphyxia following breech presentation.*

\_\_\_\_\_ (Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

*R T Mauer (Registrar) M.D.*  
*Jan 25 1922* (Address) *Malad Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Malad Ida**1-26 1922*

## 20. UNDERTAKER

## ADDRESS

*B. C. Johnson**Malad*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

15  
22



613-226-039-415

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of PowerCity of American FallsRegistration District No. 25File No. 8

No. \_\_\_\_\_

St. \_\_\_\_\_

Hospital BulawayPrimary Registration District No. 2072Registered No. 378FULL NAME OF CHILD Elizabeth WalkerSex of Child FemaleTwin  
Triplet  
or other?and { Number  
in order  
of birth

(To be answered only in event of plural births)

Legitimacy? YrsDate of Birth Feb 26

(Month) (Day) (Year)

FULL NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born at 1:15 P.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Richard F. Noth

(Physician or midwife)

Given names added from a supplemental report.

Address American Falls, Id.Filed 3-1 1922

Registrar

Richard J. Noth  
Registrar

STATE OF TEXAS

COUNTY OF DALLAS

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

RECEIVED  
MAY 14 1922  
BUREAU OF VITAL STATISTICS

Boise, Idaho, ..... 4/7 ..... 1922

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City American Falls File Number 99554  
Street .....  
County Power Registration Dist. No. ....  
Sex of Child Female Date of Birth Feb 26 1922  
Father Hyrum Smith Walker Full Name Mother Sarah Edith Davis Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Elizabeth Walker Child's Name in Full  
Sarah Edith Walker Signature of Father or Mother

DEC 29 1965

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

## CERTIFICATE OF DEATH

37334

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Paver*City of *Rockland*If death occurs away from  
usual residence, give facts  
called for under special  
information.Registration District No. *23*Primary Registration District No. *2072*

(No. .... St.)

File No. ....

Registered No. *146*  
If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.2. FULL NAME *not named*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Female*

## 4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.*Single*

## 6. DATE OF BIRTH.

*Feb 28 1922*  
(Month) (Day) (Year)

## 7. AGE

*Still born*  
Yrs. Mos. ds.IF LESS than 1 day  
how many .... hrs. or  
min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which em-  
ployed (or employer)

## 9. BIRTHPLACE

(State or Country)

*American Falls*10. NAME OF  
FATHER*Byrum Smith Walker*11. BIRTHPLACE  
OF FATHER

(State or Country)

*Idaho*12. MAIDEN NAME  
OF MOTHER*Edith Davis*13. BIRTHPLACE  
OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs. S. S. Walker by R. F. M.*  
(Address) *Rockland Idaho*

## 15.

Filed *2-27* 1922*Richard F. North*

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Feb 26 1922*  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from  
191... to 191...that I last saw h... alive on 191...  
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH\* was as follows:

*Still born*  
*7 months*

(Duration) Yrs. mos. ds.

Contributor *Mother in labor*  
(Secondary) *anemia*

(Duration) Yrs. mos. ds.

(Signed) *Richard F. North* M. D.*Feb 26 1922* (Address) *American Falls*\*State the Disease Causing Death; or in deaths from Violent  
Causes, state (1) Means of Injury; and (2) whether Accidental,  
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)At place In the  
of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... daysWhere was disease contracted  
if not at place of death?Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Rockland, Idaho Feb 28 1922*

## 20. UNDERTAKER

## ADDRESS

*none*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

236 (21-042-236)  
PLACE OF BIRTH

RECEIVED

MAR 20 1922

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Twiss Falls

City of Twiss Falls

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 37

File No. 29596

Hospital \_\_\_\_\_

Primary Registration District No. 1085

Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Infant Storey

(Certificate of no value without full name of child.)

Sex of Child m-

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and { Number  
in order  
of birth

Legiti-  
mate? W-

Date of birth Feb 21 1922  
(Month) (Day) (Year)

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth. one

Number of children of this mother now living, including present birth. none

FULL  
NAME

FATHER

Not known

FULL  
MAIDEN  
NAME

MOTHER

Regina Storey

RESIDENCE

not known

RESIDENCE

Twiss Falls

COLOR

V

AGE AT LAST  
BIRTHDAY

V  
(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

22-  
(Years)

BIRTHPLACE

V

BIRTHPLACE

Idaho -

OCCUPATION

V

OCCUPATION

unknown

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

Hillborn 6 a- M.  
(Name, title, grade, etc.)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

John T. Coughlin  
M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Twiss Falls

Filed

Feb. 9 1922

John T. Coughlin  
Registrar.

УГОЛОВНО-ПРАВОВАЯ ОТВЕТСТВЕННОСТЬ ЗА НЕЗАКОННОЕ  
ПОСРЕДСТВОМ ТЕЛЕГРАФА, А ТАКЖЕ ЗА НЕЗАКОННОЕ  
ПОСРЕДСТВОМ ТЕЛЕГРАФА, А ТАКЖЕ ЗА НЕЗАКОННОЕ  
ПОСРЕДСТВОМ ТЕЛЕГРАФА, А ТАКЖЕ ЗА НЕЗАКОННОЕ



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. **37347**

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of *Twin Falls*  
City of *Twin Falls*Registration District No. *37*Primary Registration District No. *1085*

(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Infant Stores*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED *S*

(Write the word.)

## 6. DATE OF BIRTH

*2 - 21 - 1922*  
(Month) (Day) (Year)

## 7. AGE

*0* Yrs. *0* Mos. *0* ds.IF LESS than 1 day  
how many *0* hrs.  
or *0* min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*unknown*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*unknown*

## 12. MAIDEN NAME OF MOTHER

*Requia Stores*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*John T. Dougherty*  
*Twin Falls, Ida.*15. *Marick* 19 *22*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Feb. 21 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*2 - 21 - 1922* to *2 - 21 - 1922*  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_  
and that death occurred on the date stated above, at *4* M.

The CAUSE OF DEATH\* was as follows:

*Still born*

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *John T. Dougherty* M. D.

19 \_\_\_\_ (Address) \_\_\_\_\_

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

*Twin Falls*

## DATE OF BURIAL

*2/27 1922*

## 20. UNDERTAKER

*R. J. Crossman*

## ADDRESS

*Twin Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

794-2061 042-392

## PLACE OF BIRTH

County of *Twin Falls*City of *Twin Falls*No. *517* - *5th Ave. West*Hospital *At home*FULL NAME OF CHILD *Evelyn Maxine Bennett* (*Still born*)

Sex of Child <i>Female</i>	Twin Triplet or other? <i>No</i>	and Number in order of birth <i>1</i>	Legitimate? <i>Yes</i>	Date of Birth <i>Feb 6</i> 19 <i>22</i>
(To be answered only in event of plural births)				(Month) (Day) (Year)

FULL NAME <i>L. M. Bennett</i>	FATHER
RESIDENCE <i>517-5th Ave N. Twin Falls Ida</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>26</i> (Years)
BIRTHPLACE <i>Boise Ida.</i>	
OCCUPATION <i>Laborer O.S. &amp; R.R.</i>	

FULL MAIDEN NAME <i>Mina Disenber</i>	MOTHER
RESIDENCE <i>Twin Falls Ida.</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>18</i> (Years)
BIRTHPLACE <i>Texas.</i>	
OCCUPATION <i>House wife</i>	

Number of child of this mother, including present birth *1* Number of children of this mother now living, including present birth *0*

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Still born* (Born alive or stillborn) at *2:00 P.M.* on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *Chas. J. ...*  
*Physician*  
 (Physician or midwife)

Given names added from a supplemental report.

Address *Twin Falls*  
 Filed *Feb 9 1922*  
*John J. Laughlin*  
 Registrar

# INFORMED FOR CENSUS BUREAU

THIS CARD IS TO BE FILLED OUT BY THE HEAD OF THE HOUSEHOLD OR BY SOME OTHER PERSON HAVING KNOWLEDGE OF THE FACTS CONCERNING THE PERSONS NAMED HEREON. IT IS TO BE FILLED OUT FOR EVERY PERSON WHO WAS BORN IN THE UNITED STATES OR WHO WAS BORN IN A FOREIGN COUNTRY AND WHO WAS AT THE TIME OF THE CENSUS IN THE UNITED STATES OR WHO WAS BORN IN A FOREIGN COUNTRY AND WHO WAS AT THE TIME OF THE CENSUS IN THE UNITED STATES.

STATE OF OHIO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

CHILD'S NAME <i>John William Smith</i>		SEX Male	
DATE OF BIRTH <i>Jan 15 1900</i>		PLACE OF BIRTH <i>Cincinnati, Ohio</i>	
FATHER'S NAME <i>John Smith</i>		MOTHER'S NAME <i>Mary Smith</i>	
FATHER'S OCCUPATION <i>Engineer</i>		MOTHER'S OCCUPATION <i>Housewife</i>	
CHILD'S COLOR White		CHILD'S HAIR Brown	
CHILD'S EYES Blue		CHILD'S BUILD Medium	
CHILD'S AGE AT LAST BIRTHDAY <i>10</i>		CHILD'S AGE AT BIRTH <i>10</i>	
CHILD'S BIRTHDAY <i>Jan 15</i>		CHILD'S BIRTHDAY <i>1900</i>	
CHILD'S BIRTHPLACE <i>Cincinnati, Ohio</i>		CHILD'S BIRTHPLACE <i>Cincinnati, Ohio</i>	
CHILD'S OCCUPATION <i>Student</i>		CHILD'S OCCUPATION <i>Student</i>	
NUMBER OF CHILDREN OF THIS MOTHER NOW LIVING, INCLUDING PRESENT BIRTH: <i>3</i>			

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Number of child of this mother now living, including present birth: *3*

Signature of Physician or Midwife: *[Signature]*

Signature of Registrar: *[Signature]*

Signature of Clerk: *[Signature]*

## CERTIFICATE OF DEATH

37024

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Twin Falls*Registration District No. *87*Primary Registration District No. *1085*

File No. \_\_\_\_\_

City of *Idaho Falls*

(No. \_\_\_\_\_) St. \_\_\_\_\_

Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Hazel Chasine Pruitt*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Female White*

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

*Feb 6 1922*

(Month)

(Day)

(Year)

## 7. AGE

*2* Yrs. *0* Mos. *0* ds. *0*IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

*Twin Falls*

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*L M Pruitt*

## 11. BIRTHPLACE OF FATHER

*Boise Idaho*

(State or Country)

## 12. MAIDEN NAME OF MOTHER

*Mina Simblee*

## 13. BIRTHPLACE OF MOTHER

*Wardlaw*

(State or Country)

*Texas*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*L M Pruitt*(Address) *Twin Falls Idaho*

## 15.

Filed

*Feb 7 1922**1922**John S. Gausman*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Feb*

(Month)

*6*

(Day)

*1922*  
(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*at birth Feb 6 1922, still born*that I last saw him *still born* *19*

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

(Duration)

Yrs.

mos.

ds.

Contributory  
(Secondary)*detached placenta*

(Duration)

Yrs.

mos.

ds.

(Signed)

*Chasine Pruitt*

M. D.

*2/6 1922* (Address) *Twin Falls Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

*Twin Falls*

## DATE OF BURIAL

*2/7 1922*

## 20. UNDERTAKER

*J S Pruitt*

## ADDRESS

*Twin Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

381-122,001-291

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. 5. No. 11-C-25m-8-8-17

County of AdaRECEIVED  
MAY 1922

## CERTIFICATE OF BIRTH

S 99668

City of BoiseRegistration District No. 2

File No. ....

No. 1119 RossiPrimary Registration District No. 1004

Registered No. ....

Hospital .....

FULL NAME OF CHILD Still Born

Sex of Child <u>male</u>	Twin Triplet or other? <u>no</u>	and Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of Birth <u>Mar 22</u> 19 <u>22</u> (Month) (Day) (Year)
FULL NAME <u>Hale Thatcher</u>	FATHER	FULL MAIDEN NAME <u>Millie Badbury</u>	MOTHER	
RESIDENCE <u>1119 Rossi St Boise</u>		RESIDENCE <u>Boise Ada</u>		
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)	
BIRTHPLACE <u>Preston, Ida</u>		BIRTHPLACE <u>Liberty, Bear Lake Co Ida</u>		
OCCUPATION <u>Laborer Janitor</u>		OCCUPATION <u>Housewife</u>		
Number of child of this mother, including present birth <u>3</u>		Number of children of this mother now living, including present birth <u>2</u>		

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was..... at 6 a M. on the date above stated. (Emetive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature) Geo. H. Handy

(Physician or midwife)

Address Boise IdahoFiled Apr 7 1922 P. H. Paul

Registrar

Registrar

1. 100 2. 100 3. 100

*[Faint handwritten notes, possibly bleed-through from the reverse side.]*

John J. Hall



MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

485-207-001-693  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED  
MAY 6 1922  
SUNDAY

CERTIFICATE OF BIRTH

S

99719

County of Ada.

City of \_\_\_\_\_

Registration District No. 124

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2202

Registered No. 126

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child Female Twin Triplet or other? (To be answered only in event of plural births) and Number in order of birth Legitimate? Yes. Date of Birth 3 22 (Month) (Day) (Year)

FATHER  
FULL NAME Charles B. Myers.

MOTHER  
FULL MAIDEN NAME Minnie Willhite.

RESIDENCE Kuna, Ida.

RESIDENCE Kuna, Ida.

COLOR White. AGE AT LAST BIRTHDAY 39. (Years)

COLOR White. AGE AT LAST BIRTHDAY 38. (Years)

BIRTHPLACE Mo.

BIRTHPLACE Kansas.

OCCUPATION General Store Keeper.

OCCUPATION Housewife.

Number of child of this mother, including present birth \_\_\_\_\_ Number of children of this mother now living, including present birth \_\_\_\_\_

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Stillborn. at 4-00-P.M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. Coleman

Physician.  
(Physician or midwife)

Given names added from a supplemental report. \_\_\_\_\_

Kuna, Ida.

Address \_\_\_\_\_

Filed 5-4, 19 22 W. B. Stevens  
Registrar.

1991

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH.

County of Ada.City of Kuna.

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Registration District No. 124Primary Registration District No. 2202(No. 1)

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 37411Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.

(Write the word.)

## 6. DATE OF BIRTH.

March- 7- 1922.  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many hrs. or  
min.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

## 9. BIRTHPLACE

(State or Country) Ada Co. Idaho.

## 10. NAME OF FATHER

Charles B. Myers.

## 11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

## 12. MAIDEN NAME OF MOTHER

Minnie Willhite.

## 13. BIRTHPLACE OF MOTHER

(State or Country) Kansas.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles B. Myers.

(Address)

Kuna, Ida.

## 15.

Filed

5-4-1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw h. alive on 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still born and was dead for some time before delivery.(Duration) Yrs. mos. ds.Contributory Disease of the cord.  
(Secondary)(Duration) Yrs. mos. ds.(Signed) M. D.3-6-1922 (Address) Ada Co. Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.  
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic)—"Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

217-230-003-239  
PLACE OF BIRTH

RECEIVED  
APR 21 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

99797

S 72

County of Bannock  
City of Pocatello  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 28 File No. \_\_\_\_\_  
Hospital Boone's Primary Registration District No. 461 Registered No. 4299  
FULL NAME OF CHILD Evelyn Bagley  
(Certificate of no value without full name of child.)

Sex of Child <u>D.</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate <u>yes</u>	Date of birth <u>3/30</u> 192 <u>2</u> (Month) (Day) (Year)
------------------------	---	-----------------------	--

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth... 1 Number of child of this mother now living, including present birth... 0

FATHER		MOTHER	
FULL NAME <u>Eva Bagley</u>	FULL MAIDEN NAME <u>Ruth Stratford</u>		
RESIDENCE <u>Pocatello, Ida</u>	RESIDENCE <u>Same</u>		
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>34</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>29</u> (Years)		
BIRTHPLACE <u>Brigham City, Utah</u>	BIRTHPLACE <u>Cody, Utah</u>		
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

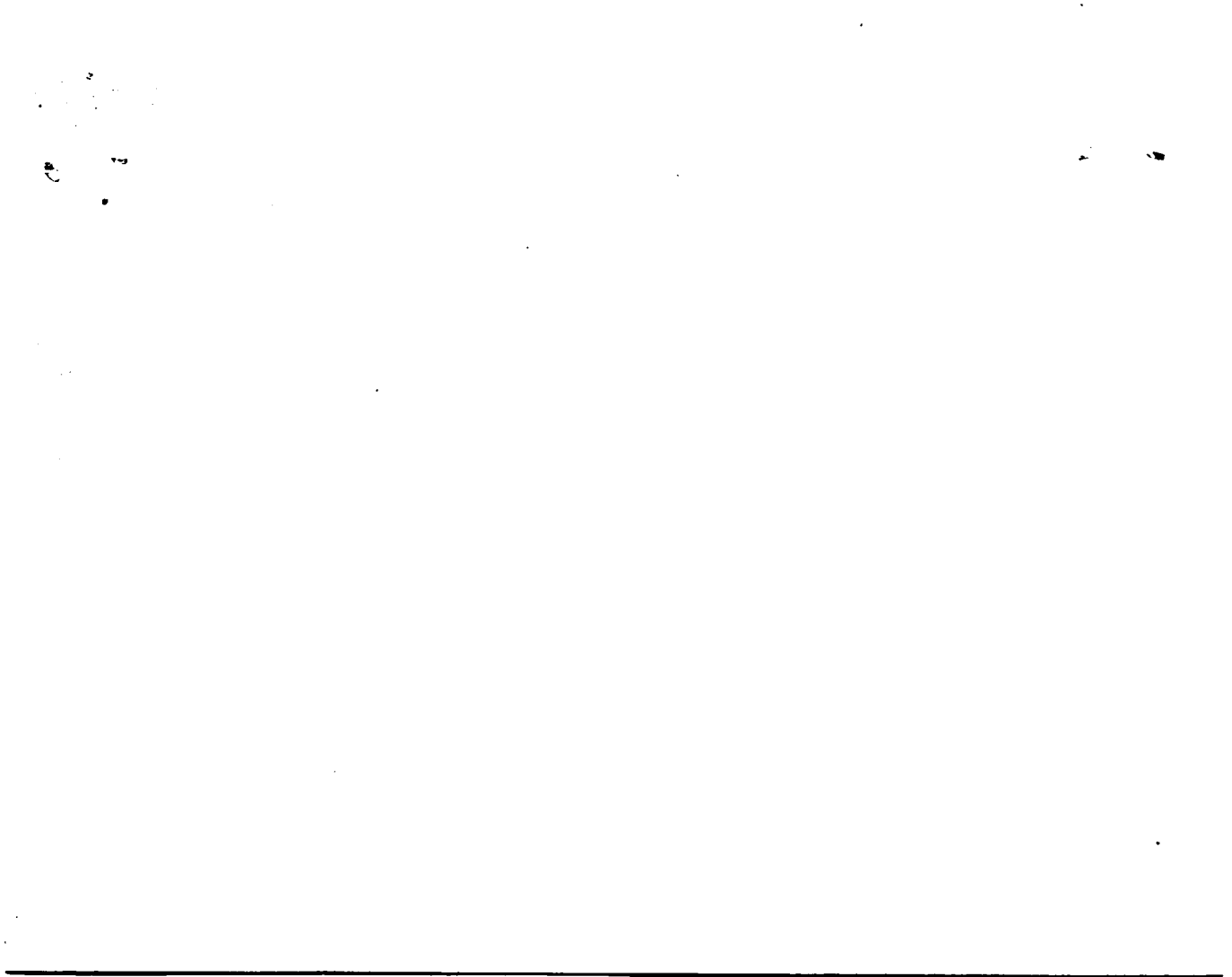
I hereby certify that I attended the birth of this child, who was female at 7 A. M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
Registrar.

Address Pocatello  
Filed 4/1 1922 [Signature] Registrar.



FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

28

2161

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

4/1

19

22

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 i N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
 and the number of each, in order of birth stated.

366-2091006-685

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
 DEPARTMENT OF VITAL STATISTICSCounty of BinghamRECEIVED  
 APR 21 1922  
 CERTIFICATE OF BIRTHCity of MarelandRegistration District No. 21File No. S

99879

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2174Registered No. 139

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Malissia W. Lome

Sex of Child <u>female</u>	Twin Triplet or other? <u>1</u> and <u>1</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of Birth <u>3</u> <u>9</u> <u>1922</u> (Month) (Day) (Year)
----------------------------	--	-----------------------------------	------------------------	---

FULL NAME FATHER James LomeFULL MAIDEN NAME MOTHER Mary Malissia WheelerRESIDENCE MarelandRESIDENCE MarelandCOLOR White AGE AT LAST BIRTHDAY 39 (Years)COLOR White AGE AT LAST BIRTHDAY 34 (Years)BIRTHPLACE Caligstein UtahBIRTHPLACE Prater IdahoOCCUPATION FarmerOCCUPATION HousewifeNumber of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 5

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was dead, at 4 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mary A. Hatch  
midwife  
 (Physician or midwife)

Given names added from a supplemental report.

Address Mareland  
 Filed April 5 1922 Met. Helen E. Fitch  
 Registrar

THIS RECORD IS THE PROPERTY OF THE BUREAU OF VITAL STATISTICS  
 IT IS LOANED TO YOU FOR YOUR INFORMATION ONLY  
 IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER  
 WITHOUT THE WRITTEN PERMISSION OF THE BUREAU  
 ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
 DATE 11-15-2000 BY 60322 UCBAW/BJS

STATE OF MARYLAND  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF BIRTH

COUNTY OF <u>ANNAPOLIS</u> CITY OF <u>ANNAPOLIS</u>		FULL NAME OF CHILD <u>JOHN JAMES</u>	
REGISTRATION DISTRICT NO. <u>1</u> PRIMARY REGISTRATION DISTRICT NO. <u>1</u>		HOSPITAL <u>ANNAPOLIS</u>	
DATE OF BIRTH <u>1912</u> TIME OF BIRTH <u>11:00</u>		SEX <u>MALE</u>	
FULL NAME OF FATHER <u>JOHN JAMES</u> MAIDEN NAME <u>JOHN JAMES</u> RESIDENCE <u>ANNAPOLIS</u>		FULL NAME OF MOTHER <u>MARY ANN</u> MAIDEN NAME <u>MARY ANN</u> RESIDENCE <u>ANNAPOLIS</u>	
AGE AT LAST BIRTHDAY <u>1</u> (Years) BIRTHPLACE <u>ANNAPOLIS</u>		AGE AT LAST BIRTHDAY <u>1</u> (Years) BIRTHPLACE <u>ANNAPOLIS</u>	
OCCUPATION <u>None</u>		OCCUPATION <u>None</u>	
SIGNATURE OF FATHER <u>JOHN JAMES</u> SIGNATURE OF MOTHER <u>MARY ANN</u> SIGNATURE OF BIRTH ATTENDING PHYSICIAN <u>JOHN JAMES</u> SIGNATURE OF REGISTRAR <u>JOHN JAMES</u>		SIGNATURE OF BIRTH ATTENDING PHYSICIAN <u>JOHN JAMES</u> SIGNATURE OF REGISTRAR <u>JOHN JAMES</u>	

I hereby certify that I attended the birth of this child upon the date above stated.

When there was no attending physician or midwife, the birth was attended by the mother or a relative. A birth record may be made by the mother or a relative, but it must be verified by the registrar.

Given names added from a supplemental report.

Address ANNAPOLIS

Physician (not midwife) JOHN JAMES

Registrar JOHN JAMES

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bingham  
 City of Moreland

Registration District No. 121Primary Registration District No. 2194(No. 121 St.)

If death occurs away from  
 usual residence, give facts  
 called for under special in-  
 formation.

## 2. FULL NAME OF DECEASED

Infant Lowe

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 37495Registered No. 46

If death occurred in a hos-  
 pital, institution or camp,  
 give its NAME instead of  
 street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED Single  
 (Write the word.)

## 6. DATE OF BIRTH

March 9th 1922  
 (Month) (Day) (Year)

## 7. AGE

Yrs.    Mos.    ds.   

IF LESS than 1 day  
 how many    hrs.  
 or    min.?

## 8. OCCUPATION

(a) Trade, profession or  
 particular kind of work. None  
 (b) General nature of in-  
 dustry, business or estab-  
 lishment in which employ-  
 ed (or employer).

## 9. BIRTHPLACE

(State or Country)

Moreland, Idaho

## 10. NAME OF FATHER

James LeRoy D. Lowe

## 11. BIRTHPLACE OF FATHER

(State or Country)

Franklin, Idaho

## 12. MAIDEN NAME OF MOTHER

Mary Melissa Wheeler

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. March 11 1922 Mr. Walter E. Pattee  
 Filed         

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

March 9th 22  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

   19    to    19     
 that I last saw h.    alive on    19     
 and that death occurred on the date stated above, at    M.

The CAUSE OF DEATH\* was as follows:

Still born(Duration)    Yrs.    mos.    ds.Contributory  
(Secondary)(Duration)    yrs.    mos.    ds.

(Signed)

J. B. Davis

M. D.

3/11 1922 (Address) Blackfoot, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death    yrs.    mos.    days. In the State    yrs.    mos.    days.

Where was disease contracted  
 if not at place of death?

Former or  
 usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Moreland

## DATE OF BURIAL

3/13 1922

## 20. UNDERTAKER

E. E. Egle

## ADDRESS

Blackfoot.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

566-115-008-473  
PLACE OF BIRTH

County of Bingham

City of Berkeley

No. E & South St.

Hospital .....

FULL NAME OF CHILD Norman Howard

Sex of Child <u>M</u>	Twin <input type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input checked="" type="checkbox"/> (To be answered only in event of plural births)	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of Birth <u>March 15 1922</u> (Month) (Day) (Year)
-----------------------	---	-----------------------------------	------------------------	--

FULL NAME Norman Howard

RESIDENCE Berkeley, E & South

COLOR W AGE AT LAST BIRTHDAY 30  
(Years)

BIRTHPLACE Colorado

OCCUPATION Stock buyer

FULL MAIDEN NAME Betty McCoy

RESIDENCE Berkeley, E & South

COLOR W AGE AT LAST BIRTHDAY 26  
(Years)

BIRTHPLACE Kansas

OCCUPATION Housewife

Number of child of this mother, including present birth... 2 ... Number of children of this mother now living, including present birth... 1 ...

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Steve born at 1 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]

Given names added from a supplemental report.

(Physician or midwife)

Address 1344 1st St. Berkeley

Filed April 18 1922

Registrar

Registrar

RECEIVED BUREAU OF VITAL STATISTICS  
1922 CERTIFICATE OF BIRTH

File No. 99889

Registered No. 148

Primary Registration District No. 1007

RECEIVED  
JAN 21 1964  
NEW YORK  
SECOND

Form with multiple sections and fields, including:

- Top section: **RECEIVED** stamp and handwritten notes.
- Section 1: **PERSONAL DATA** (Name, Address, Date of Birth, etc.)
- Section 2: **EDUCATION** (School, Degree, etc.)
- Section 3: **OCCUPATION** (Job Title, Employer, etc.)
- Section 4: **RESIDENCE** (Current and Previous Addresses)
- Section 5: **RELIGION** (Religious Affiliation)
- Section 6: **ACTIVITIES** (Hobbies, Sports, etc.)
- Section 7: **REFERENCES** (References to other records or documents)

Handwritten entries and stamps are visible throughout the form.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

254-127.006-165  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

99914

County of Bingham RECEIVED  
City of Blackfoot APR 21 1922  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2194 Registered No. 174  
FULL NAME OF CHILD unnamed Lundeen  
(Certificate of no value without full name of child.)

Sex of Child male Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legitimate? yes Date of birth 2/22 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	<u>Rasmus Lundeen</u>	FULL MAIDEN NAME	<u>Laura Jones</u>
RESIDENCE	<u>Blackfoot 3da</u>	RESIDENCE	<u>Blackfoot</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>26</u> (Years)	AGE AT LAST BIRTHDAY	<u>19</u> (Years)
BIRTHPLACE	<u>Denmark</u>	BIRTHPLACE	<u>Kentucky</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 1:30 p. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. O. Hueston M.D.  
(Physician or midwife)

Give names added from a supplemental report.

Address Blackfoot 3da  
Filed April 16 1922 Mrs. Thelma E. Pattee  
Registrar.

SECRET - NO FORN DISSEM

५३

**SECRET**

## Zeitstrahl

RECEIVED

THE UNIVERSITY OF CHICAGO

100-443887-100

**SECRET**

100

vol-to-oi  
stand to  
5 to 1000

Continued Page 10

There is also a possibility that the

Number of cases with a downward trend, including those with

RENTON

1947

110  
500

TRAJ TA TCA  
YACRYE

02-23

LEAD TA 20-  
YAKUTSK

SECRET

ਅੰਤਰਰਾਸ਼ਟਰੀ

1. DATE OF EXAMINATION \_\_\_\_\_

10-10-68

[illegible]

20151111



## ✓ CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. **37160**Registered No. **40**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

Registration District No. **121**County of **Bingham**Primary Registration District No. **2194**City of **Blackfoot**(No. **RH 4** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **unnamed Knudsen**

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

**Male** **White** **Single**  
(Write the word.)

6. DATE OF BIRTH

**2** **27** **1922**  
(Month) (Day) (Year)

7. AGE

**still Born**  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)**none**

9. BIRTHPLACE

(State or Country) **Maryland**

10. NAME OF FATHER

**Rasmus Knudsen**

11. BIRTHPLACE OF FATHER

(State or Country) **Denmark**

12. MAIDEN NAME OF MOTHER

**Lena Jones**

13. BIRTHPLACE OF MOTHER

(State or Country) **Kentucky**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Rasmus Knudsen**(Address) **Maryland**

15.

Filed **Feb. 27** 19**22** **Mr. Thos. E. P. Smith**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

**Feb** **27** **1922**  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased ~~from~~**Feb 27** 19**22** to **19**

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH was as follows:

**Still Born**

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. O. Humphreys** M. D.**2/27** 19**22** (Address) **Blackfoot Ida**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

**Maryland Cem.** **2** **28** 19**22**

20. UNDERTAKER

ADDRESS

**E. J. Puck** **Blackfoot**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 25 1966

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

695-9-766-1-122  
County of \_\_\_\_\_

BUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

99924

City of \_\_\_\_\_ Sandpoint  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ City Hospital \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_ still born  
(Certificate of no value without full name of child.)

Sex of Child Male	Twins or other? Triplets } and { Number in order of birth	Legitimate? No	Date of birth 4/24/22 1922 (Month) (Day) (Year)
-------------------	---	----------------	--

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	Jeff Findlay	FULL MAIDEN NAME	Mabel Goosh
RESIDENCE	unknown	RESIDENCE	Sandpoint
COLOR	White	COLOR	White
AGE AT LAST BIRTHDAY	30 (Years)	AGE AT LAST BIRTHDAY	17 (Years)
BIRTHPLACE	Unknown	BIRTHPLACE	Idaho
OCCUPATION	laborer	OCCUPATION	waitress

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 6:30 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_  
physician (Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address \_\_\_\_\_  
Filed \_\_\_\_\_ 1922 \_\_\_\_\_  
Registrar.



A

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of **Bonner**  
City of **Sandpoint**RECEIVED  
MAY 6 1922  
BUREAU OF VITAL STATISTICSRegistration District No. **78**  
Primary Registration District No. **255**  
(No. ) (St.)File No. **37542**

Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Stillborn**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED**male** | **white** | (Write the word.)

## 6. DATE OF BIRTH

**4/24/22**  
(Month) (Day) (Year)

## 7. AGE

**stillborn**IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) **Idaho**

## 10. NAME OF FATHER

**Jeff Findlay**

## 11. BIRTHPLACE OF FATHER

(State or Country) **unknown**

## 12. MAIDEN NAME OF MOTHER

**Maybelle Goosh**

## 13. BIRTHPLACE OF MOTHER

(State or Country) **Idaho**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **David Goosh**  
(Address) **Sandpoint, Ida**

## 15.

Filed **May 4** 19**22**  
**John Allen**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**4/24/22**  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from  
**stillborn** 19....., to 19.....  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date stated above, at..... M.  
The CAUSE OF DEATH\* was as follows:**Eclampsia in mother**

..... (Duration) ..... Yrs..... mos..... ds.

Contributory  
(Secondary)

..... (Duration) ..... yrs..... mos..... ds.

(Signed) **M. R. Wallentin** M. D.**5-2, 19 22** (Address) **Sandpoint Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

**Sandpoint, Ida** | **April 25, 1922**

## 20. UNDERTAKER | ADDRESS

**David Goosh** | **Sandpoint, Ida**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each, in order of birth stated.

289-111,009-465  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S  
99950

St. Idaho Registration District No. 78 File No. 2155  
Primary Registration District No. 2155 Registrar [Redacted]

FULL NAME OF CHILD Shields

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? <u>—</u> and <u>—</u> Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of birth <u>3-18</u> 192 <u>2</u> (Month) (Day) (Year)
-----------------------	--	------------------------	--

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER		MOTHER	
FULL NAME	<u>Thomas Shields</u>	FULL MAIDEN NAME	<u>William M. Homer</u>
RESIDENCE	<u>Calverton</u>	RESIDENCE	<u>Calverton</u>
COLOR	<u>White</u>	COLOR	<u>M</u>
AGE AT LAST BIRTHDAY	<u>43</u> (Years)	AGE AT LAST BIRTHDAY	<u>38</u> (Years)
BIRTHPLACE	<u>Canada</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Male at 11:03 M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. T. Anderson

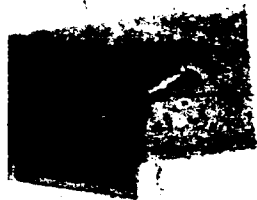
(Physician or midwife)

Address Sanic Point, Ida

Filed April 6 1922

Registrar.

Registrar.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## RECEIVED CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

County of \_\_\_\_\_  
City of \_\_\_\_\_Registration District No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_  
(No. \_\_\_\_\_ St.)File No. **38745**  
Registered No. \_\_\_\_\_If death occurs away from  
usual residence, give facts  
called for under special  
information.

## 2. FULL NAME

*Shields*If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX *m* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

*3 11 22*  
(Month) (Day) (Year)

7. AGE

*Still born*  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs. or  
min.?

8. OCCUPATION

(a) Trade, profession or  
particular kind of work...  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which employ-  
ed (or employer)

9. BIRTHPLACE

(State or Country)

*Cabaret Idca*10. NAME OF  
FATHER*Thomas Shields*11. BIRTHPLACE  
OF FATHER

(State or Country)

*Canada*12. MAIDEN NAME  
OF MOTHER*Lillian Brown*13. BIRTHPLACE  
OF MOTHER

(State or Country)

*Mont*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*E. T. Anderson*

15.

Filed

*Big + 1922*

Local Registrar

16. DATE OF DEATH

*Not known*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Still born*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *E. T. Anderson* M. D.19 (Address) *Sanpoint Idca*\*State the DISEASE CAUSING DEATH; or in deaths from UNKNOWN CAUSES, state (1)  
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted  
if not at place of death?Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Heron, Mont**March 12, 1922*

20. UNDERTAKER

ADDRESS

*Father*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

469-1091010-453  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

99996

County of Bonneville  
City of Blaine  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 3 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 218-0 Registered No. 70  
FULL NAME OF CHILD Horris

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other <u>1</u>	and	Number in order of birth <u>1</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>Feb 9</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	--------------------------------------	-----	---	-----------------------------	--

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FULL NAME <u>Frank Horris</u>	FATHER	FULL MAIDEN NAME <u>Iva Horris</u>	MOTHER
RESIDENCE <u>Idaho</u>		RESIDENCE <u>Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Salt Lake City, Ut.</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Clark</u>		OCCUPATION <u>H.W.</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was born dead at 12:30 a. M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Iva Horris

(Physician or midwife)

Give names added from a supplemental report.

Address Idaho Falls, Ida

Filed Mar 10 1922

Registrar.

Registrar.

THE NEW YORK PUBLIC LIBRARY  
ASTOR LENOX TILDEN FOUNDATION  
500 5TH AVENUE  
NEW YORK 17, N.Y.

THE NEW YORK TIMES

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7-10-68

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FULL

PATENT

MAY 1968

NO. 1000

1000

RECEIVED

SECRET

\_\_\_\_\_

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the situation.

... cannot be held responsible for the actions of the...

\_\_\_\_\_

100-443887-100

... and a most beautiful view.

10-10-68

100-443887-100

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

275-117-614-962  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

County of Canyon  
City of Notus  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Hospital \_\_\_\_\_  
Primary Registration District No. 2005  
Registration District No. 3  
File No. 100036  
Registered No. 61  
FULL NAME OF CHILD Baby Speck (Stillborn)  
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Twins or other?	and	Number in order of birth <u>1</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Mar 17</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	----------------------------	-----	---	-----------------------------	--

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth. \_\_\_\_\_ Number of child of this mother now living, including present birth. \_\_\_\_\_

FATHER	MOTHER
FULL NAME <u>Fred Speck</u>	FULL MAIDEN NAME <u>Gwendolyn Robb</u>
RESIDENCE <u>Notus</u>	RESIDENCE <u>Notus</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Notus Ida.</u>	BIRTHPLACE <u>Wilford Ida.</u>
OCCUPATION <u>Farmer.</u>	OCCUPATION <u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. M. Henry

(Physician or midwife)

Give names added from a supplemental report.

Address Caldwell Ida.

Filed Mar. 24 - 1922 John V. Meyer

Registrar.

Registrar.

1915

STATE OF NEW YORK

DEPARTMENT OF COMMERCE

RECEIVED

MAY 15 1922

BUREAU OF VITAL  
STATISTICS

## STATE OF IDAHO

DEPARTMENT

PUBLIC WELFARE

MAY 8 - 1922

Boise, Idaho, ..... 192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City .....  
                  { Street .....  
                  { County, .....

File Number **100036** ✓

Registration Dist. No. ....

Sex of Child, ..... **Male** .....

Date of Birth ..... 192....

Father .....  
                                Full NameMother .....  
                                Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*The baby was born dead and therefore  
was not named.* Child's Name in Full

*Mrs. Fred W. Specht*  
Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 37592  
Registered No. 39

## 1. PLACE OF DEATH

County of Canyon  
City of Caldwell, Idaho  
Registration District No. 2005  
Primary Registration District No. 2005  
(No.) (St.)If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

## 2. FULL NAME

Baby Specht

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

March 17- 1922  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work.(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer).

## 9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF  
FATHER

Fred W. Specht

11. BIRTHPLACE  
OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME  
OF MOTHER

Guendolyn Robb

13. BIRTHPLACE  
OF MOTHER

(State or Country)

St. Anthony, Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred W. Specht

(Address)

Idaho

## 15.

Filed

Mar. 18- 1922

John B. Meyers

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

March 17- 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Mar. 17- 1922 to Mar. 17- 1922  
that I last saw him alive on Mar. 17- 1922  
and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH\* was as follows:

Hard labor & from str-  
angulation by cord  
around neck.

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. M. Henry M. D.

3-18-1922

(Address) Caldwell, Idaho

\*State the Disease Causing Death; or in deaths from violent causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted  
if not at place of death?Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Idaho

## DATE OF BURIAL

3-18-1922

## 20. UNDERTAKER

C. B. Peckham

## ADDRESS

Caldwell, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

15-2-a

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

381-206-014-693  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

100056

County of Canyon **RECEIVED**  
City of Nampa **APR 21 1922**  
No. Rt 2 Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2026 Registered No. \_\_\_\_\_  
FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Mar 6</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth \_\_\_\_\_ Number of child of this mother now living, including present birth \_\_\_\_\_

FATHER	MOTHER
FULL NAME <u>Wm E Chambers</u>	FULL MAIDEN NAME <u>Bertha M Wilson</u>
RESIDENCE <u>Nampa</u>	RESIDENCE <u>Nampa</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Tennessee</u>	BIRTHPLACE <u>Washington</u>
OCCUPATION <u>Farming</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 12:30 a. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

M. S. Fink, M.D.

(Physician or midwife)

M. B.

Give names added from a supplemental report.

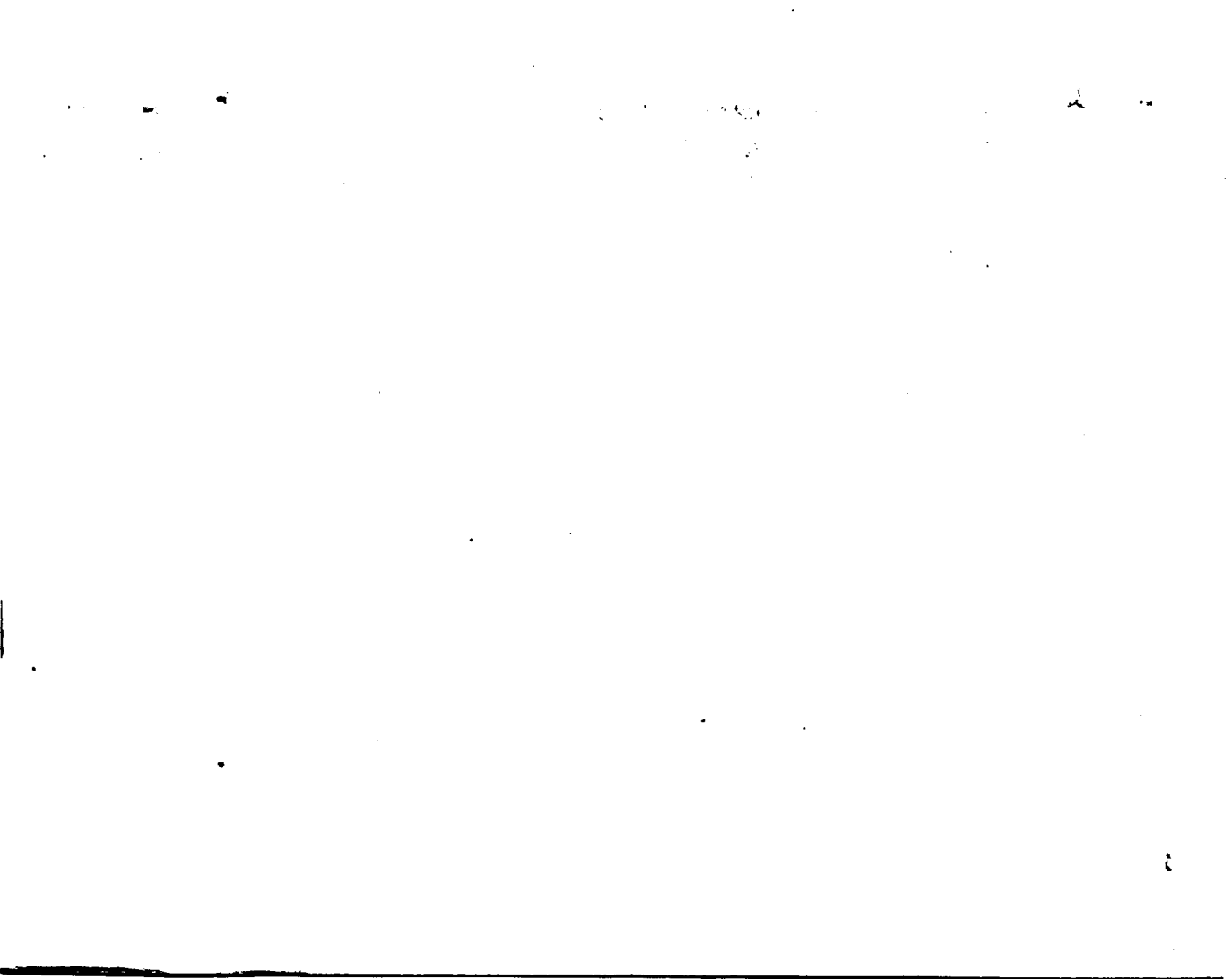
Address \_\_\_\_\_

Filed

April 10 1922 Searle D. Dadds

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

County of Canyon District No. 7  
City of Raynham Registration District No. 2006  
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still born

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 37577

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH

March 6

(Month)

(Day)

1922 (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
how many... 0 hrs. or  
... 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country)

Nampa Ida

10. NAME OF FATHER

Wm. E. Chambers

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

B. M. Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

April 10 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 6

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1922 to March 6 1922 that I last saw her dead on March 6 1922 and that death occurred on the date stated above, at 1:05 P.M.

The CAUSE OF DEATH\* was as follows:

Prematurity

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 Yrs. 0 mos. 0 ds.

(Signed)

M. J. F. M. D.

Apr 10 1922 (Address) Nampa Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa

DATE OF BURIAL

3-6 1922

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

719-218'016-843

PLACE OF BIRTH

County of Cassia

City of Malta

No. \_\_\_\_\_ St.

Hospital at home

FULL NAME OF CHILD

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S-  
100083

Registration District No. 119 File No. \_\_\_\_\_

Primary Registration District No. 2198 Registered No. \_\_\_\_\_

Sex of Child <u>Female</u>	Twin Triplet or other? <u>no</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of Birth <u>Jan 18 1922</u> (Month) (Day) (Year)
----------------------------	----------------------------------	-----	-----------------------------------	------------------------	--

FATHER FULL NAME <u>Elmer Parker</u>	MOTHER FULL MAIDEN NAME <u>Celia Hutchison</u>
RESIDENCE <u>Malta Idaho</u>	RESIDENCE <u>Malta Idaho</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>45</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE <u>Logan Utah</u>	BIRTHPLACE <u>Sublett, Idaho</u>
OCCUPATION <u>Stock Farmer</u>	OCCUPATION <u>House wife</u>

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born, at 5 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E J Luter MD

(Physician or midwife)

Given names added from a supplemental report.

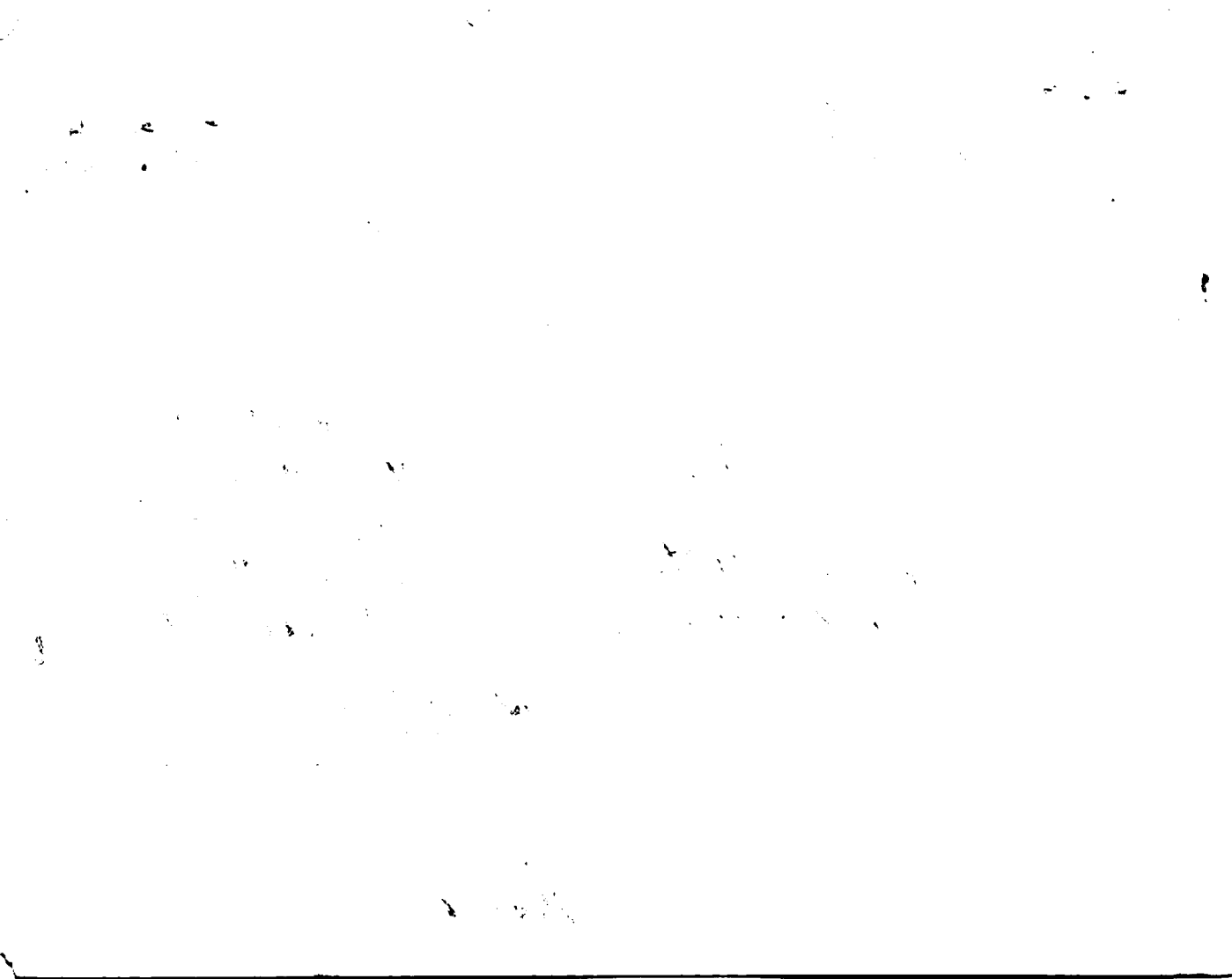
19

Address Malta Idaho

Filed Mar, 10 1922

Registrar

Registrar





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 37604

## 1. PLACE OF DEATH.

County of Cassia  
City of Malta

Registration District No. 119  
Primary Registration District No. 2198  
(No. .... St.)

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

## 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white single  
Write the word.)

## 6. DATE OF BIRTH.

Jan 18 1922  
(Month) (Day) (Year)

## 7. AGE

still born  
Yrs. .... Mos. .... ds.

IF LESS than 1 day  
how many .... hrs. or  
..... min.)

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

Infant

## 9. BIRTHPLACE

(State or Country)

Malta Idaho

## 10. NAME OF FATHER

Ether Parke

## 11. BIRTHPLACE OF FATHER

(State or Country)

Logan Utah

## 12. MAIDEN NAME OF MOTHER

Celia Parke

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Sublett Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Ether Parke  
Malta Idaho

## 15.

Filed

Apr 15 1922 E J Dater  
Local Registrar

## 16. DATE OF DEATH

Jan 18 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Jan 18 1922 to Jan 18 1922  
that I last saw him alive on still born 1922  
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

Monstrosity

(Duration) .... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) E J Dater M. D.\*15-1922 (Address) Malta Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Malta Jan 19 1922  
20. UNDERTAKER none ADDRESS .....

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

150-0

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

413-111-017-756

Form V. S. No. 11-C--25m-7-21-19

PLACE OF BIRTH  
*Clark*

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

City of *Dubuois*

Registration District No. *125*

File No. *100112*

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. *2203*

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

*Maloney*

Sex of Child <i>Male</i>	Twin <i>Yes</i> or other? <i>(To be answered only in event of plural births)</i>	and {	Number in order of birth <i>2</i>	Legit mate? <i>yes</i>	Date of Birth <i>Mar 11</i> 19 <i>22</i> (Month) (Day) (Year)
--------------------------	---	-------	-----------------------------------	------------------------	--

FULL NAME <i>Thomas J Maloney</i>	FATHER
RESIDENCE <i>Dubuois</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>44</i> (Years)
BIRTHPLACE <i>Indiana</i>	
OCCUPATION <i>Miner</i>	

FULL MAIDEN NAME <i>Emmie George</i>	MOTHER
RESIDENCE <i>Dubuois</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>34</i> (Years)
BIRTHPLACE <i>Iowa</i>	
OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth *9* Number of children of this mother now living, including present birth *8*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_, at *10:30 a* M.  
on the date above stated. (~~Born alive~~ stillborn)

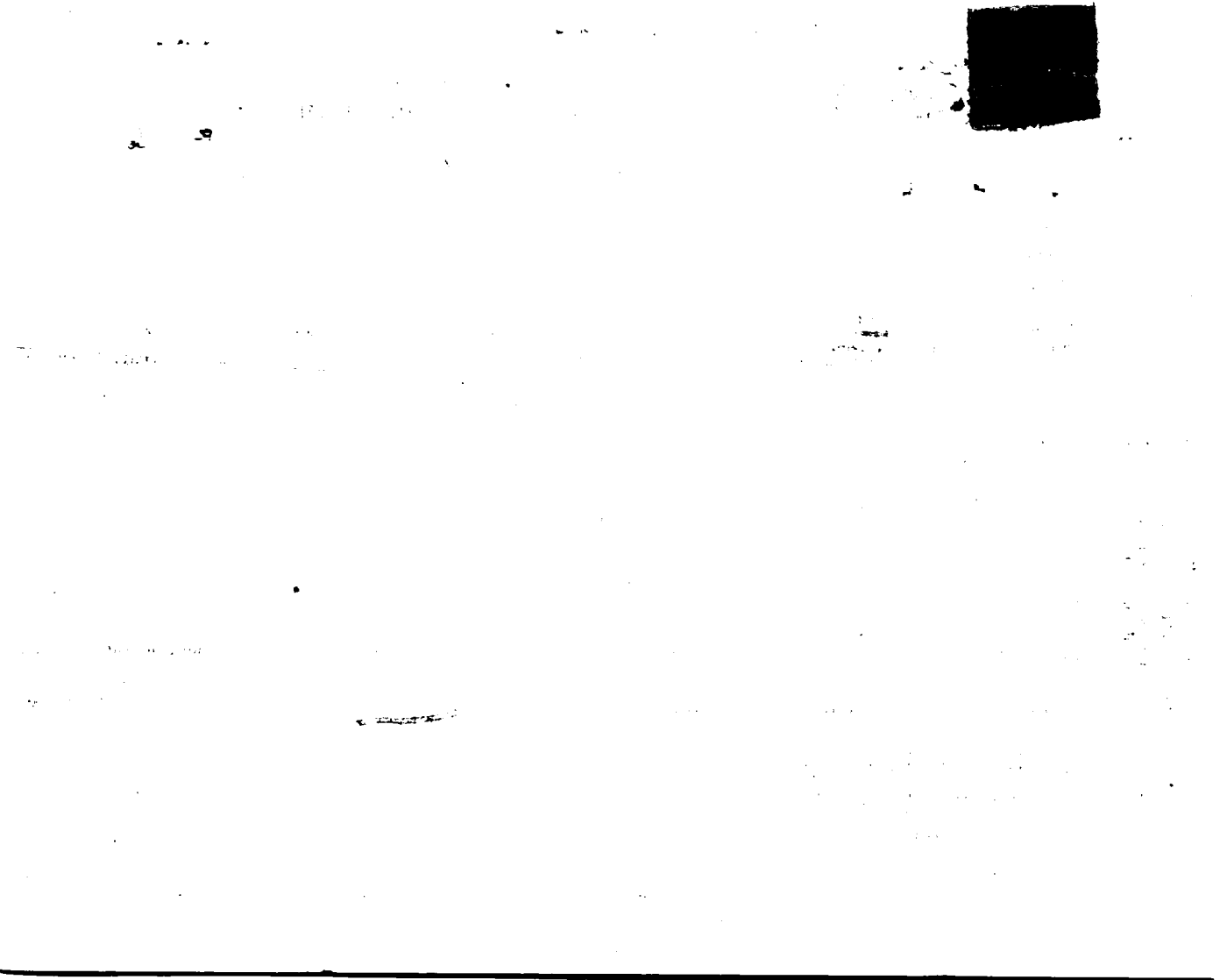
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *Dr. Jones MD*  
(Physician or midwife)

Given names added from a supplemental report.

Address *Dubuois Idaho*  
Filed *Mar 11* 19*22* *Dr. Jones MD*  
Registrar

Registrar



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of ClarkCity of SubawRegistration District No. 125Primary Registration District No. 2203

(No. \_\_\_\_\_ St.)

File No. 37610

Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Maloney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

Nov111922

(Month)

(Day)

(Year)

## 7. AGE

Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds. \_\_\_\_\_

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Subaw Idaho

## 10. NAME OF FATHER

Thomas J Maloney

## 11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

## 12. MAIDEN NAME OF MOTHER

Eunice George

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr J J Maloney

(Address)

Subaw Idaho

## 15.

Filed

Mar 11 1922CE Jones MS

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Mar111922

(Month)

(Day)

(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 \_\_\_\_\_ to 19 \_\_\_\_\_

that I last saw him alive on 19 \_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still born  
difficult labor

(Duration) Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

Contributory  
(Secondary)

(Duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

(Signed)

CE Jones

M. D.

3-11-1922 (Address) Subaw Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

Subaw Idaho

## DATE OF BURIAL

Mar 12 1922

## 20. UNDERTAKER

None

## ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

264-101-024-799

PLACE OF BIRTH

County of Gooding

City of Gooding

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

FULL NAME OF CHILD

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
APR 21 1922

Registration District No. 24

Primary Registration District No. \_\_\_\_\_

Form V. S. No. 11-C-25m-7-21-19

S

File No. 100183

Registered No. \_\_\_\_\_

Sex of Child Male Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legiti mate? Yes Date of Birth Mar 1 19 22  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Ernest Baden  
RESIDENCE Bliss  
COLOR White AGE AT LAST BIRTHDAY 32  
(Years)  
BIRTHPLACE Utah  
OCCUPATION Rancher

MOTHER  
FULL MAIDEN NAME Ellen Grimes  
RESIDENCE Bliss  
COLOR White AGE AT LAST BIRTHDAY 36  
(Years)  
BIRTHPLACE Iowa  
OCCUPATION Housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn 7ms. at 12 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. E. Lamb per A. Zingg  
(Physician or midwife)

Given names added from a supplemental report.

Address Gooding Idaho  
Filed 3-13-19 rr J. C. M. D.  
Registrar

Registrar

Registrar

CHAD 30 1472

CHAD 30 1472



STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, MAY 8 - 1922 192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place { City .....  
of { Street .....  
Birth { County .....

File Number 100183 .....

Registration Dist. No. ....

Sex of Child Male .....

Date of Birth .....192...

Father .....  
Full Name

Mother .....  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

.....  
Child's Name in Full

.....  
Signature of Father or Mother

*Returned*

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

635-106026-415  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

100207

County of Jefferson  
City of Paris

No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 98 File No. 100207

Hospital \_\_\_\_\_ Primary Registration District No. 3276 Registered No. 111

FULL NAME OF CHILD

Not Named Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Boy</u>	Twin Triplet or other? <u>4</u> and	Number in order of birth	Legitimate? <u>yes</u>	Date of birth. <u>Jan 6</u> 192 <u>2</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? Stillborn

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 5

FULL NAME <u>Sam S. Hellen</u>	FATHER	FULL NAME <u>Anna Davis</u>	MOTHER
RESIDENCE <u>Paris Idaho</u>		RESIDENCE <u>Paris Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Utah</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>farmer</u>		OCCUPATION <u>Physician</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Sam F. Price  
Physician  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Paris Idaho  
Filed 4-10 1922 Ray H. Fisher  
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 37650  
Registered No. 15

1. PLACE OF DEATH

Registration District No. 98  
County of Jefferson Primary Registration District No. 2176  
City of Idaho (No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word.)

6. DATE OF BIRTH 1-6-1922  
(Month) (Day) (Year)

7. AGE Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho  
(State or Country)

10. NAME OF FATHER Sam A. Flitton

11. BIRTHPLACE OF FATHER Utah  
(State or Country)

12. MAIDEN NAME OF MOTHER Anna Davis

13. BIRTHPLACE OF MOTHER Idaho  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Anna Flitton  
(Address)

15. 4-10-1922 Ray H Fisher  
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1-6-22  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19  
that I last saw h. Stillborn alive on 19  
and that death occurred on the date stated above, at M.  
The CAUSE OF DEATH\* was as follows:

Stillborn  
(Duration) Yrs. mos. ds.  
Contributory (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) Sam J Price M. D.  
1-7-1922 (Address) Ririe

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days  
Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Ririe DATE OF BURIAL 1-7-1922

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

294-202-028943  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Kootenai  
City of Coeur d'Alene  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 30 File No. 100227  
Hospital \_\_\_\_\_ Primary Registration District No. 1051 Registered No. 1231  
FULL NAME OF CHILD Not Named Brunell  
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ { and } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>3</u> <u>2</u> <u>1922</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? _____	
Number of child of this mother, including present birth <u>1</u>	Number of child of this mother now living, including present birth <u>0</u>
FULL NAME <u>Chas. Brunell</u> RESIDENCE <u>Coeur d'Alene</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>21</u> (Years) BIRTHPLACE <u>Ida.</u> OCCUPATION <u>farmer</u>	FULL MAIDEN NAME <u>Athalia Rutledge</u> RESIDENCE <u>Coeur d'Alene</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>19</u> (Years) BIRTHPLACE <u>Ida.</u> OCCUPATION <u>Housewife</u>

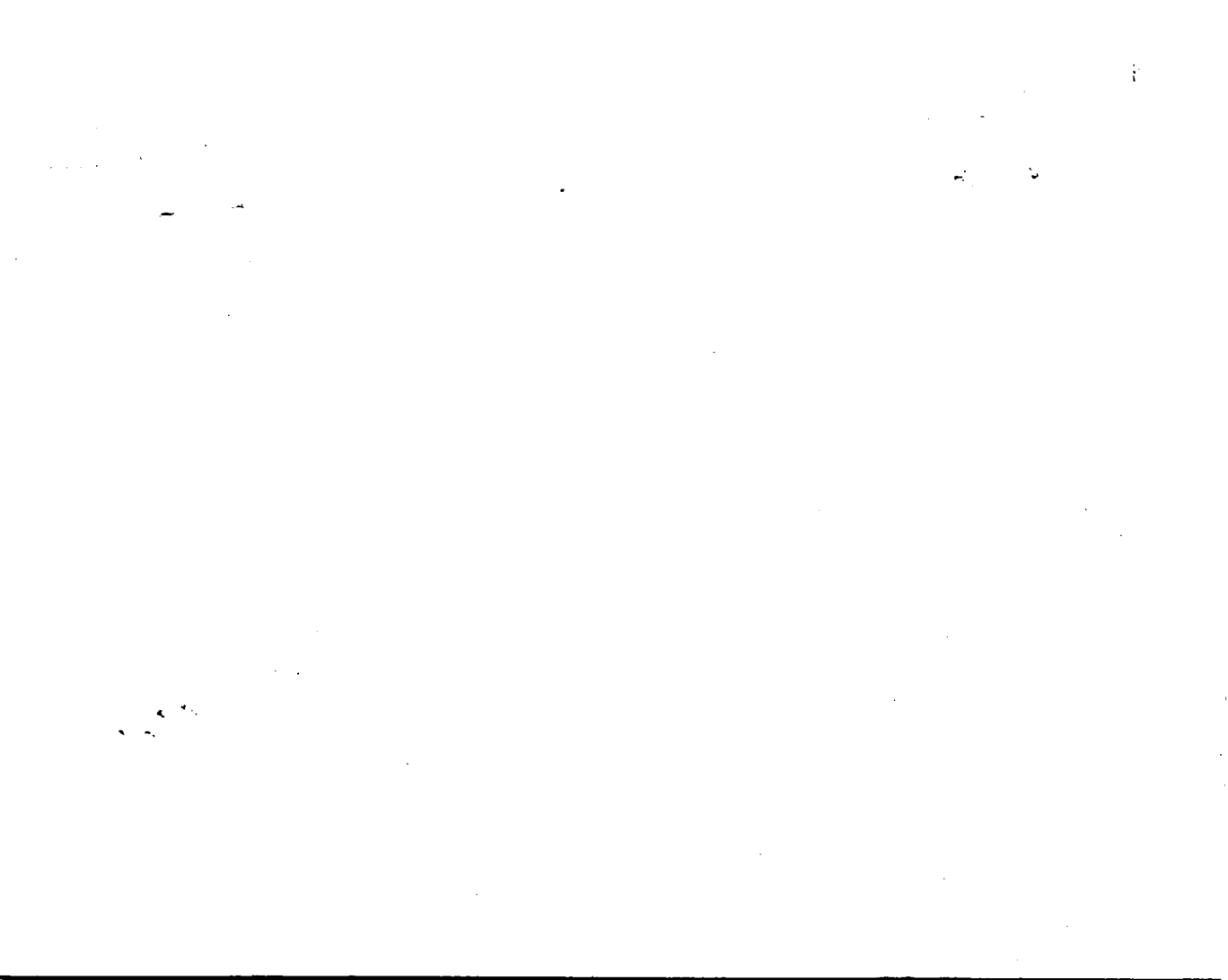
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. D. Brennan  
Physician  
(Physician or midwife)  
Address Coeur d'Alene  
Filed April 5 1922 D. D. Brennan  
Registrar.

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_\_  
\_\_\_\_\_  
Registrar.





## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of ButteCity of Butte

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Not NamedState of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 37678  
Registered No. 1841

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

Feb. Mch. 2 1922  
(Month) (Day) (Year)

## 7. AGE

Yrs. — Mos. — da. —IF LESS than 1 day  
how many — hrs.  
or — min.?

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work.
- 
- (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Chas Brunell

## 11. BIRTHPLACE OF FATHER

(State or Country)

Ida.

## 12. MAIDEN NAME OF MOTHER

Athaley Ruthford

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas. Brunell  
Cornwall, Alaska

## 15.

Filed

April 5 1922 L. D. Brennan  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Mch. 2 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, that I attended deceased from

Mch. 2 1922 to — 19—that I last saw h. — alive on — 19—and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH\* was as follows:

Premature  
Still Born  
(Duration) — Yrs. — mos. — ds.Contributory  
(Secondary)(Duration) — yrs. — mos. — ds.

(Signed)

J. D. Brennan M. D.3/2 1922 (Address) Cornwall, Alaska

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence —

## 19. PLACE OF BURIAL OR REMOVAL

Home

## DATE OF BURIAL

3/3 1922

## 20. UNDERTAKER

## ADDRESS

Chas. Brennan Cornwall, Alaska  
At large undertaker.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

**WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD**

**N. B.** In case of more than one child at birth, a **SEPARATE RETURN** must be made for each and the number of each, in order of birth stated.

**PLACE OF BIRTH**

Form V. S. No. 11-25m-1-1-18

# CERTIFICATE OF BIRTH

**S** 100-259

County of Latah RECEIVED 1980

City of Bozill MAY 6 1942

No. ~~11~~ St.

Hospital ~~XXXX~~ Primary Regis

Primary Registration District No. 2146

Registered No. \_\_\_\_\_

FULL NAME OF CHILD: Robert Thomas Ruddell

Sex of Child <i>Male</i>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <i>Yes</i>	Date of Birth <i>March 24-1927</i> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	------------------------	--

FULL NAME Greg Otis Ruddell FATHER

RESIDENCE Govill Ida

COLOR White AGE AT LAST BIRTHDAY 47  
(Years)

BIRTHPLACE Washington

OCCUPATION Laborer

FULL MAIDEN NAME **MOTHER**  
*Rebecca Elizabeth Cravell*

RESIDENCE Borip

COLOR White AGE AT LAST BIRTHDAY 44 (Years)

**BIRTHPLACE** Cuba

OCCUPATION Homemaker

Number of child of this mother, including present birth.....1..... Number of children of this mother now living, including present birth.....6.....

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:**

I hereby certify that I attended the birth of this child, who was Full Term at 1/10/41 on the date above stated. (~~Born alive~~ or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

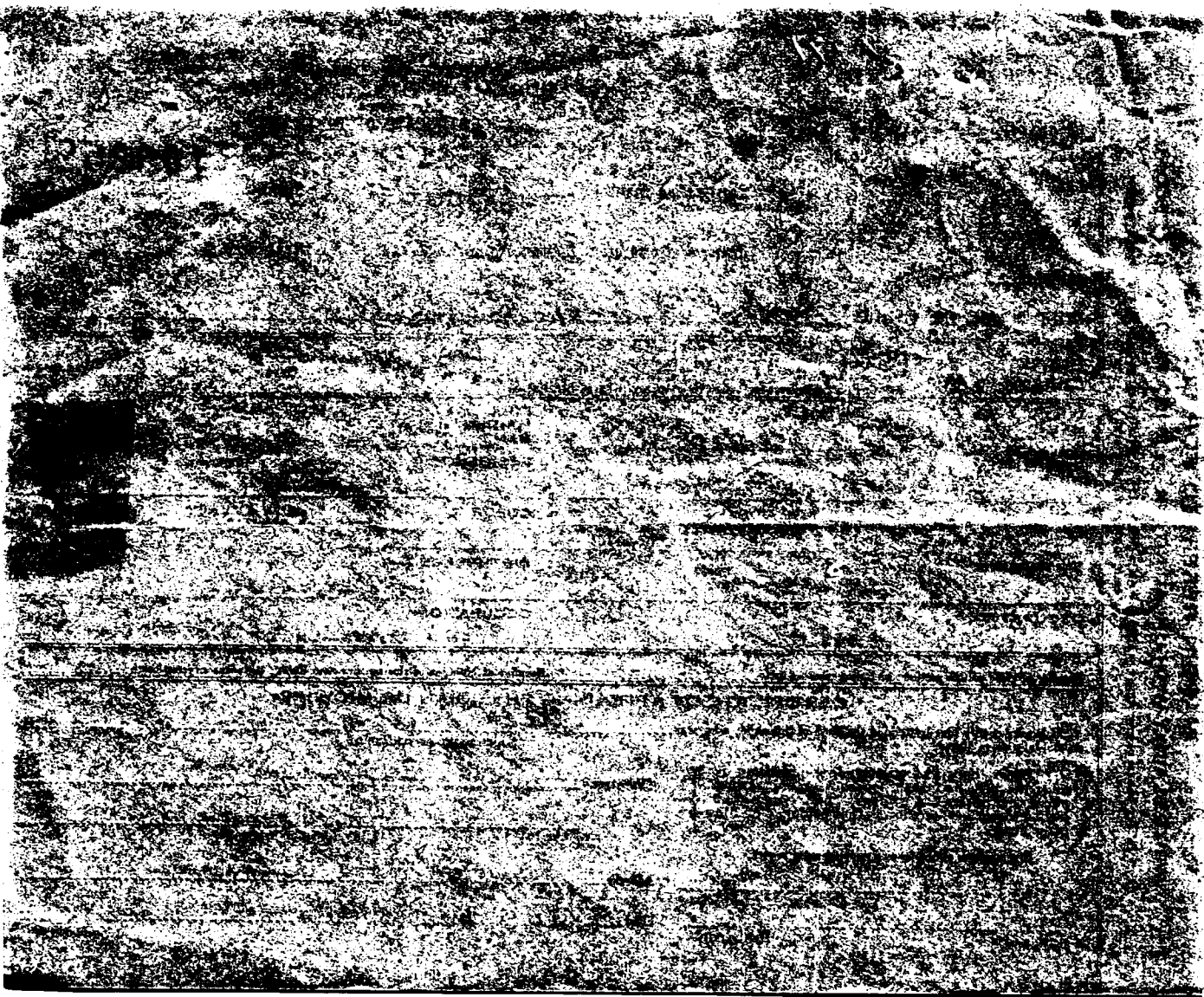
(Signature) F. C. Rissom  
Physician  
 (Physician or midwife)

Given names added from a supplemental report.

19.....  
Address.....  
Filed 3 30 1922 Mrs. J. C. Gibney  
S-Y CO. 24859 Registrar Registrar

S.Y. CO. 24550

**Registrar**



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED  
MAY 6 1922  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH  
County of Latoh Registration District No. 66  
City of Bovill Registration District No. 246 (St.)

File No. 37706  
Registered No. 37706

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Guy Thomas Ruddell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

16. DATE OF DEATH  
March 24 1922  
(Month) (Day) (Year)

6. DATE OF BIRTH  
March 24 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH\* was as follows:  
Still Born

7. AGE Still Born IF LESS than 1 day how many hrs. or min.?  
Yrs. 0 Mos. 0 ds.

8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

(Duration) Yrs. mos. ds.  
Contributory (Secondary) Placenta Previa  
(Duration) yrs. mos. ds.  
(Signed) R. Gibson M. D.  
3/24/1922 (Address) Bovill Idaho

9. BIRTHPLACE  
(State or Country) Idaho

10. NAME OF FATHER  
Guy Otis Ruddell

11. BIRTHPLACE OF FATHER  
(State or Country) Washington

12. MAIDEN NAME OF MOTHER  
Rebecca E. Crowell

13. BIRTHPLACE OF MOTHER  
(State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) G. O. Ruddell  
(Address) Bovill Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.  
Where was disease contracted if not at place of death?  
Former or usual residence

15. Filled Apr 1 1922 Wm. F. P. Gibson  
Local Registrar

19. PLACE OF BURIAL OR REMOVAL Bovill Idaho DATE OF BURIAL 3/25 1922

20. UNDERTAKER G. O. Ruddell ADDRESS Bovill Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

613-113-029-291  
PLACE OF BIRTH

County of Latah  
City of Moscow  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Hospital \_\_\_\_\_

RECEIVED  
JAN 31 1922  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH  
Registration District No. 61  
Primary Registration District No. 1011

S

File No. 100283  
Registered No. 46

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and	Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth <u>Feb. 13</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER  
FULL NAME H. J. Walker

RESIDENCE Moscow

COLOR white AGE AT LAST BIRTHDAY 29  
(Years)

BIRTHPLACE Ark

OCCUPATION Laborer

MOTHER  
FULL MAIDEN NAME Bessie M. Brazelle

RESIDENCE Moscow

COLOR white AGE AT LAST BIRTHDAY 19  
(Years)

BIRTHPLACE Wash

OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

(Physician or midwife)

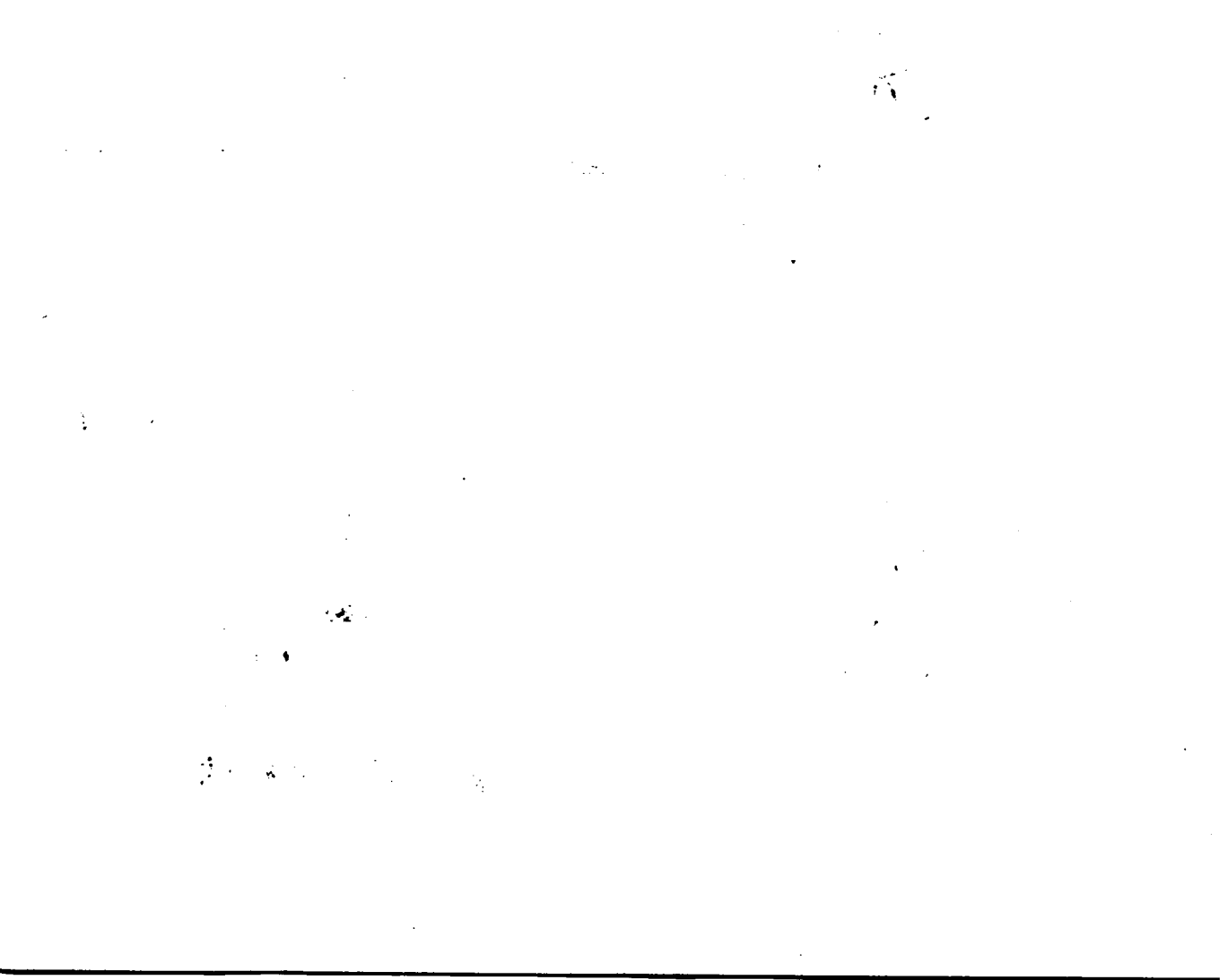
Give names added from a supplemental report.

Address \_\_\_\_\_

Filed \_\_\_\_\_

Registrar.

Registrar.





MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

231-120-031-369

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

100314

County of Blaine

City of Kamiah

Registration District No. 49

File No. 100314

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2428

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Wilfrid Blackeagle

Sex of Child <u>M</u>	Twins or other? <u>Triplet</u>	and	Number in order of birth <u>4</u>	Legitimate? <u>yes</u>	Date of Birth <u>3 20 22</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

FATHER  
FULL NAME Joseph Blackeagle  
RESIDENCE Kamiah Ida  
COLOR Ind. AGE AT LAST BIRTHDAY 27  
(Years)  
BIRTHPLACE Idaho  
OCCUPATION farmer

MOTHER  
FULL MAIDEN NAME Ida Corbett  
RESIDENCE Kamiah Ida  
COLOR Ind AGE AT LAST BIRTHDAY 26  
(Years)  
BIRTHPLACE Idaho  
OCCUPATION housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Joseph Blackeagle  
Physician arriving after birth of child  
(Physician or midwife)

Given names added from a supplemental report.

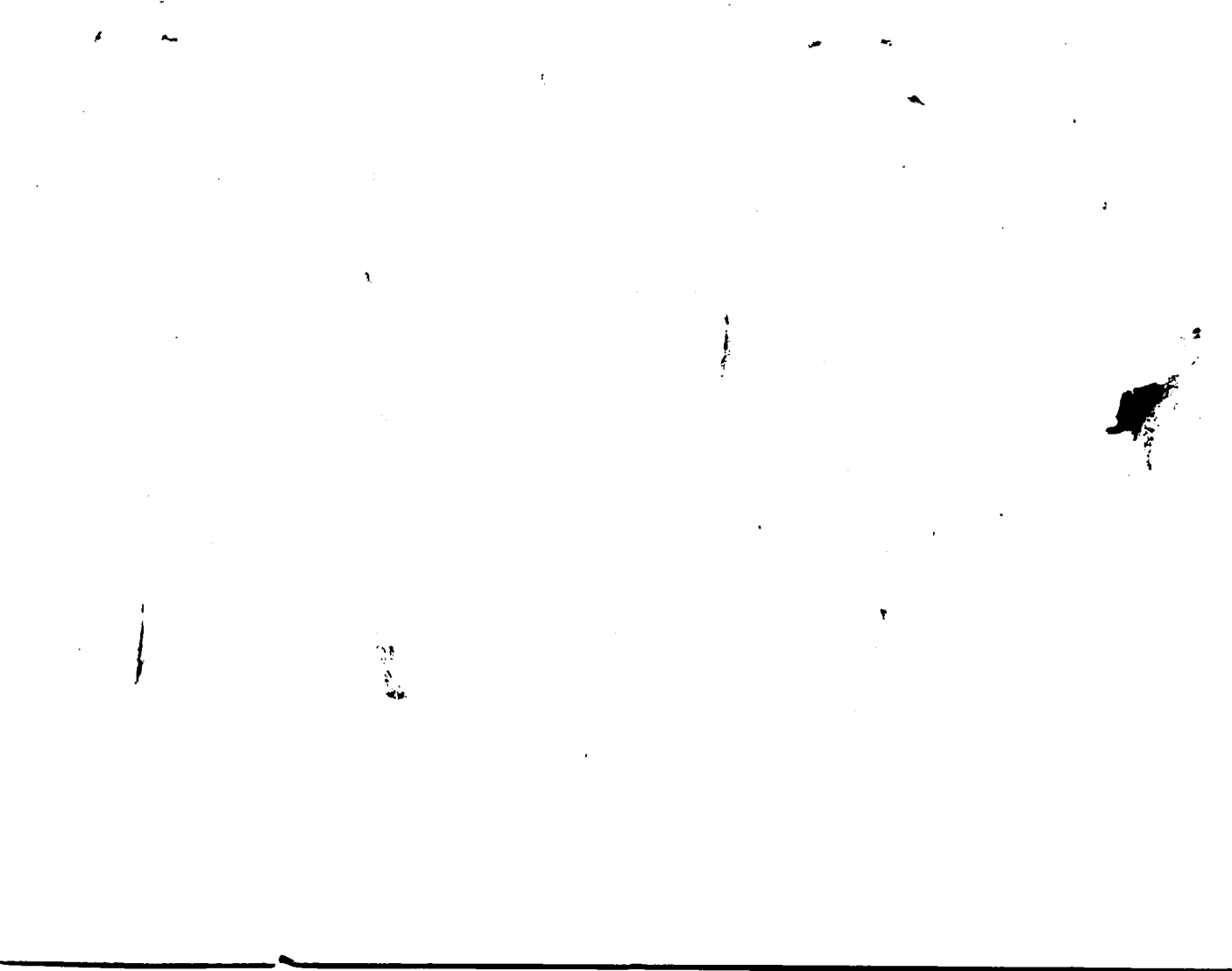
19 \_\_\_\_\_

Address Kamiah Ida

Filed 3/21 19 22

Registrar

Registrar C. J. Johnson



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH  
County of Lewis  
City of Kamiah  
Registration District No. 49  
Primary Registration District No. 2428  
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter Blackeagle

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 37723

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number,

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Single

6. DATE OF BIRTH.

March 20 1922  
(Month) (Day) (Year)

7. AGE

Child at Birth  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or  
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)

Chief

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph Blackeagle

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ida Dora Crbett

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Joseph Blackeagle  
Kamiah Ids  
3/21 1922  
G. Johnson  
Local Registrar

Filed

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 20 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/20 1922 to 3/20 1922  
that I last saw him alive on 3/20 1922  
and that death occurred on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH\* was as follows:

died at birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) G. Johnson M. D.Address Kamiah Ids

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days In the State... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ind. Cem Kamiah Ids3/22 1922

20. UNDERTAKER

ADDRESS

G. JohnsonKamiah Ids

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

719-215-032-156  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

100337

County of Lincoln

City of Shoshone

No. Spanish Rooming House

Registration District No. 16

File No.

Hospital

Primary Registration District No. 1016

Registered No. 12

FULL NAME OF CHILD John Garchina

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>    </u>	and { Number in order of birth <u>    </u>	Legitimate? <u>yes</u>	Date of birth <u>3-16</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bacteriocidal solution was used in eyes? No.

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth none

FATHER  
FULL NAME John Garchina  
RESIDENCE Shoshone Idaho  
COLOR White AGE AT LAST BIRTHDAY 24  
(Years)  
BIRTHPLACE Spain  
OCCUPATION Sheepman

MOTHER  
FULL MAIDEN NAME Marcilina Jeo  
RESIDENCE Shoshone, Idaho  
COLOR White AGE AT LAST BIRTHDAY 28  
(Years)  
BIRTHPLACE Spain  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

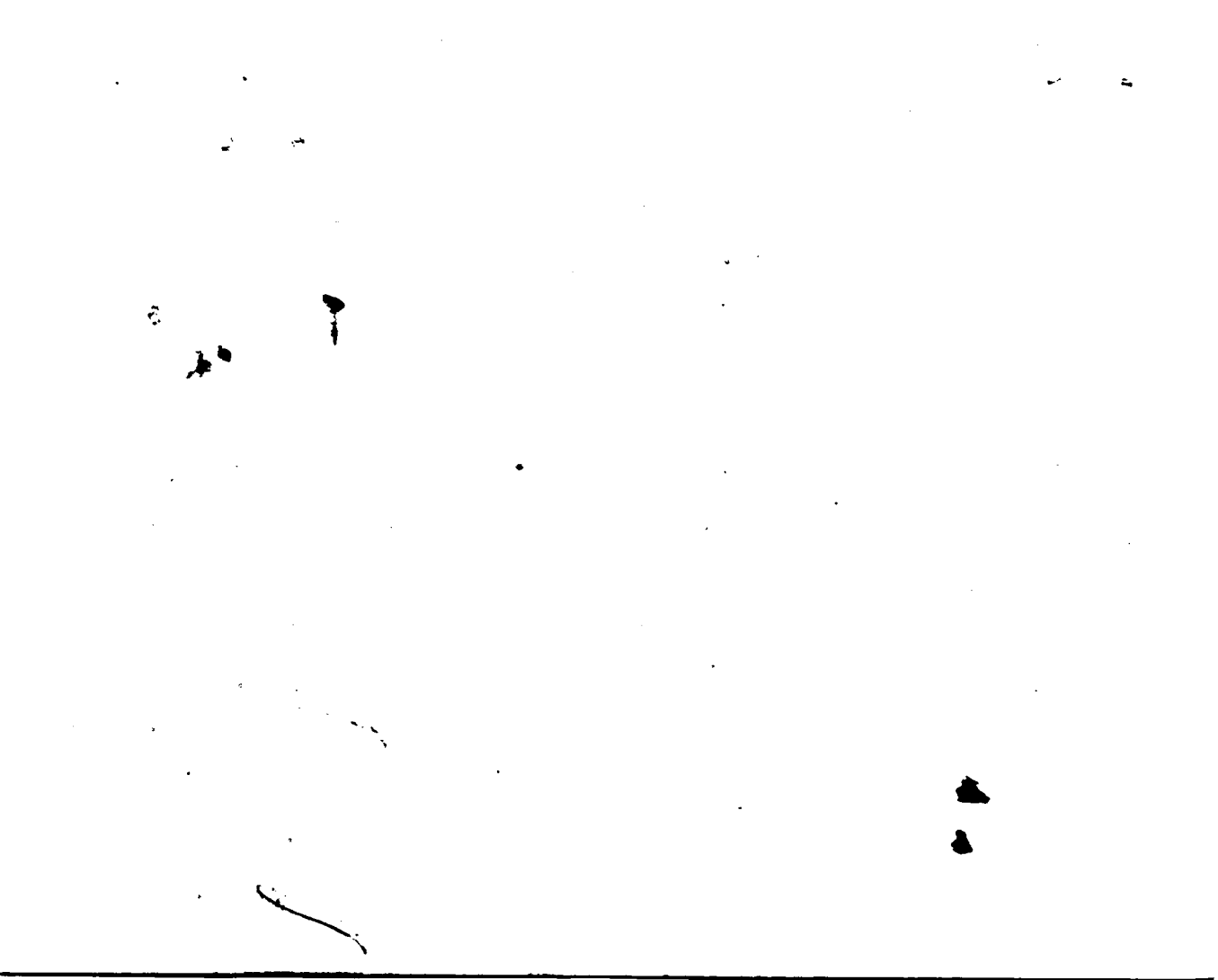
I hereby certify that I attended the birth of this child, who was dead at 4-15 3 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Herbert C. Lane M.D.  
Physician  
(Physician or midwife)

Give names added from a supplemental report.  
....., 19.....  
Registrar.

Address Shoshone, Idaho  
Filed Mich 16 1922 J. L. Lucas  
Registrar.



## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 37728  
Registered No. 5

1. PLACE OF DEATH RECEIVED  
Registration District No. ....  
County of Lincoln Primary Registration District No. ....  
City of Shashone (No. .... St.)

If death occurs away from  
usual residence, give facts  
called for under special  
information.

2. FULL NAME Joe Garchina

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
OWED, OR DIVORCED. Single  
(Write the word.)

6. DATE OF BIRTH. March 15  
(Month) (Day) (Year)

7. AGE Still Born IF LESS than 1 day  
how many ..... hrs. or  
..... min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work...  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which employ-  
ed (or employer).....

## 9. BIRTHPLACE

(State or Country) Shashone

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country) Spain

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country) Spain

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Garchina(Address) Shashone, Idaho

## 15.

File Mar 16 1922 J. J. J.

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

3 15 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
3-15-1922 to 3-15-1922  
that I last saw her Dead on 3-15 1922  
and that death occurred on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH\* was as follows:

Still born.(Duration) - Yrs. - mos. - ds.Contributory  
(Secondary) Unknown(Duration) - yrs. - mos. - ds.(Signed) Herbert C. Evans M. D.3-16 1922 (Address) Shashone Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)  
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted  
if not at place of death?.....

Former or  
usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Shashone3-16 1922

## 20. UNDERTAKER

## ADDRESS

O. J. Thuman Shashone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement  
of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

1462

154-130033-419  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Madison

City of Shornton

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

RECEIVED CERTIFICATE OF BIRTH

APR 21 1922

Registration District No. \_\_\_\_\_  
BUREAU OF VITAL

Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

100370

Registered No. \_\_\_\_\_

76

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>3-30-1922</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FATHER  
FULL NAME James M. Anderson

RESIDENCE Shornton

COLOR White AGE AT LAST BIRTHDAY 32  
(Years)

BIRTHPLACE Idaho

OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Georgia Lile Marler

RESIDENCE Shornton

COLOR White AGE AT LAST BIRTHDAY 25  
(Years)

BIRTHPLACE Utah

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn (Born alive or stillborn) M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

\_\_\_\_\_, 19\_\_\_\_

\_\_\_\_\_, 19\_\_\_\_

Registrar.

(Signature) Laird F. Rich

MD  
(Physician or midwife)

Address Rexburg Idaho

Filed 4/8 1922 J. V. Espe

Registrar.

[illegible]

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

MAY 8 - 1922

Boise, Idaho, .....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Thornton* .....  
                    { Street .....  
                    { County *Madison* .....  
Sex of Child *Male* .....  
Date of Birth *March 30* 192*2* .....

File Number .....100370.....

Registration Dist. No. ....

.....

Father *James M. Anderson* ..... Mother *Georgia Lile Anderson* .....  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*"Still born"* ..... *Baby Anderson* .....  
Child's Name in Full  
*James M. Anderson* .....  
Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

697-101-034-63  
PLACE OF BIRTH

County of Minidoka  
City of Rupert  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Hospital \_\_\_\_\_

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
RECEIVED  
APR 10 1922  
BUREAU  
CERTIFICATE OF BIRTH

S

100433

Registration District No. 19 File No. \_\_\_\_\_  
Primary Registration District No. 2015 Registered No. 32

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>1</u> } and { Number in order of birth <u>3</u>	Legitimate? <u>yes</u>	Date of birth <u>4</u> <u>1</u> <u>1922</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

What bactericidal solution was used in eyes? Ap. NO. 3

Number of child of this mother, including present birth... 3 Number of child of this mother now living, including present birth... 1

FATHER		MOTHER	
FULL NAME	<u>Clifford R Wiggins</u>	FULL MAIDEN NAME	<u>Florence Walker</u>
RESIDENCE	<u>Rupert</u>	RESIDENCE	<u>Rupert</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>28</u> (Years)	AGE AT LAST BIRTHDAY	<u>29</u> (Years)
BIRTHPLACE	<u>Utah</u>	BIRTHPLACE	<u>Kansas</u>
OCCUPATION	<u>Dentist</u>	OCCUPATION	<u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... dead ... at 12:30 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Faye Kenney M.D.

(Physician or midwife)

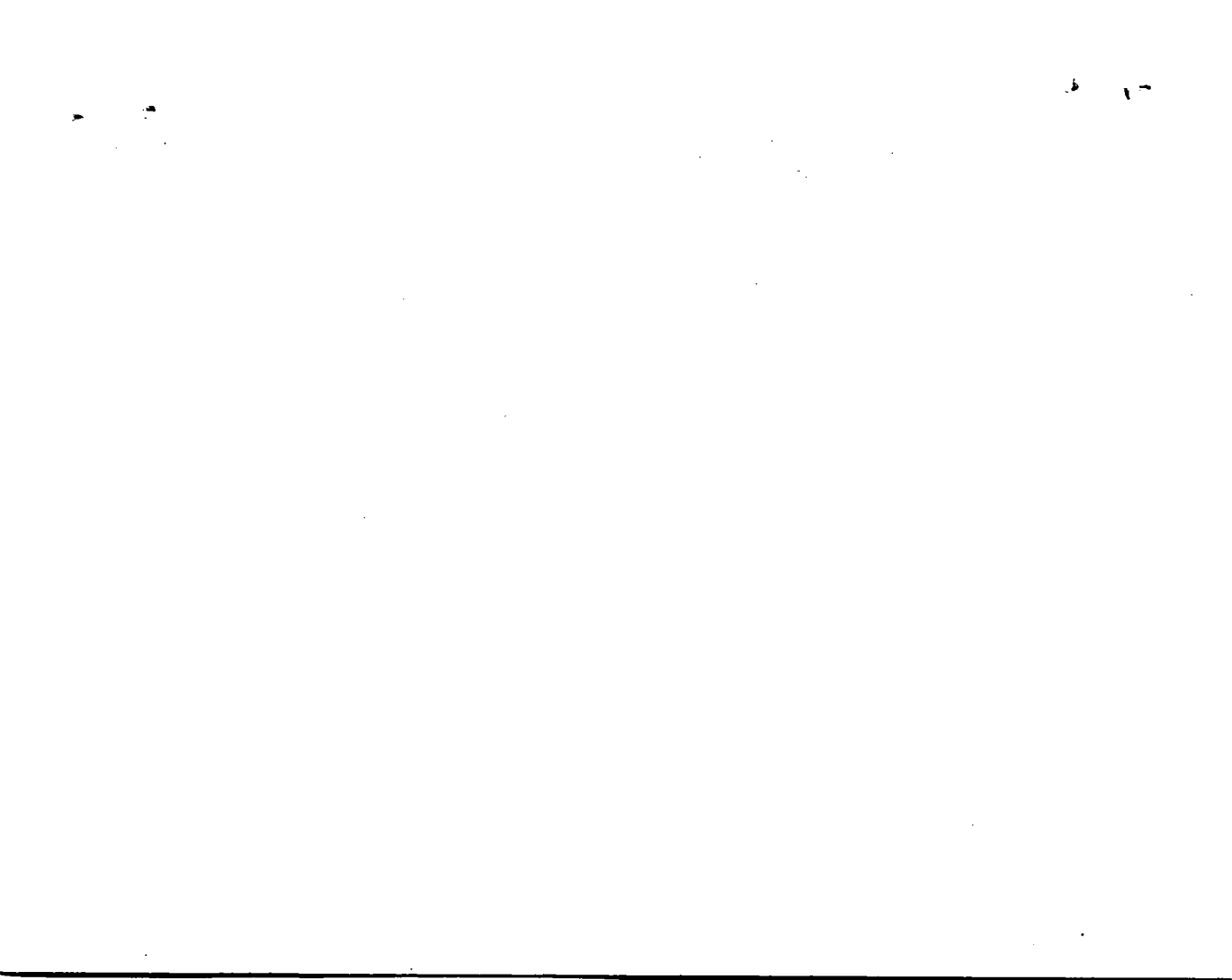
Give names added from a supplemental report.

Address Rupert Ida

Filed 4-10 1922 ED Ehnou

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

St.)

Registered No.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

May 1 1922

E. E. E. E. E.

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

19

that I last saw him..... alive on..... 19

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

(Duration) ..... Yrs..... mos..... ds.

Contributory  
(Secondary)

(Duration) ..... yrs..... mos..... ds.

(Signed)

M. D.

19..... (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

122-211035-962  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

100472

County of Nespean  
City of Leicester, Id.  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 96 File No. \_\_\_\_\_  
Hospital St. Joseph's Primary Registration District No. 1009 Registered No. 904  
FULL NAME OF CHILD Sharon Abbott

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twins Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>March 11</u> 192 <u>2</u> (Month) (Day) (Year)
----------------------------	--	--------------------------------------	-----------------------------	---

What bacterioid solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>John W. Abbott</u>	FULL MAIDEN NAME	<u>Evelyn Robinson</u>
RESIDENCE	<u>Leicester, Idaho</u>	RESIDENCE	<u>Some</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>30</u> (Years)	AGE AT LAST BIRTHDAY	<u>28</u> (Years)
BIRTHPLACE	<u>Washington</u>	BIRTHPLACE	<u>North Carolina</u>
OCCUPATION	<u>Labourer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 7 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Paul W. Johnson

(Physician or midwife)

Give names added from a supplemental report.

Address

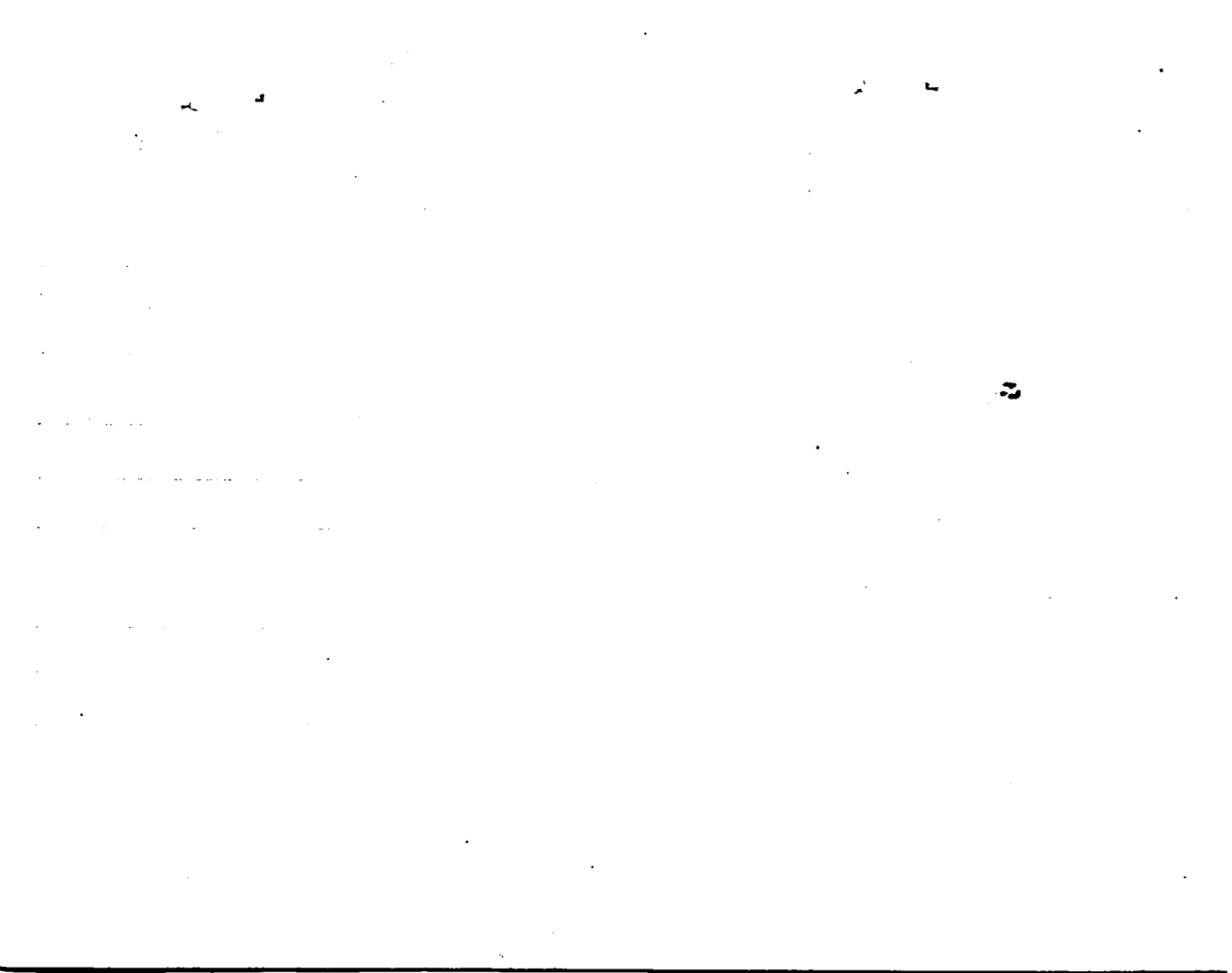
Clarkston, Wash.

Filed

Apr 10 1922 Arson E. Bruce  
Registrar.

Registrar.

Johnson



## CERTIFICATE OF DEATH

*Johnson*  
State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *37759*  
Registered No. *784*

## 1. PLACE OF DEATH

County of *Boise*  
City of *Lewiston*

Registration District No. *96*Primary Registration District No. *1009*(No. *Stillborn* St.)

If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

## 2. FULL NAME

*Leatta Abbott*

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

*Female White Single*  
(Write the word)

## 6. DATE OF BIRTH

*Mar 11 1922*  
(Month) (Day) (Year)

## 7. AGE

*Stillborn*  
IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work  
(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)

*Stillborn*

## 9. BIRTHPLACE

(State or Country)

*Ida.*

10. NAME OF  
FATHER

*J. H. Abbott*

11. BIRTHPLACE  
OF FATHER

(State or Country)

*Nash. & Co.*

12. MAIDEN NAME  
OF MOTHER

*Eula Robinson*

13. BIRTHPLACE  
OF MOTHER

(State or Country)

*N. Car.*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*J. H. Abbott*

(Address)

*1321 Snake River Ave.  
Lewiston, Ida.*

## 15.

Filed *Apr 10 1922* *Susan E. Bruce*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Mar 11 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*Mar 11 1922* to *Mar 11 1922*

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at *7 P.* M.

The CAUSE OF DEATH\* was as follows:

*still birth at 8 mos. mother had  
Belampria.*

..... (Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

..... (Duration) ..... yrs. .... mos. .... ds.

(Signed)

*Paul W. Johnson* M. D.

*2/13 1922* (Address) *Lewiston, Ida.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death..... yrs. .... mos. .... days. In the State..... yrs. .... mos. .... days

Where was disease contracted  
if not at place of death?

Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Charleston, W. Va.* *3/13 1922*

## 20. UNDERTAKER

## ADDRESS

*Bassar and Co. Lewiston*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

231-125-036-165  
PLACE OF BIRTH

County of Oneida  
City of Malad

No. .... St.

Hospital .....

FULL NAME OF CHILD .....

RECEIVED  
MAY 4 1922  
STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
BUREAU OF VITAL CERTIFICATE OF BIRTH  
STATISTICS

Registration District No. 24

Primary Registration District No. 2069

Form V. 1, No. 11-C-21-1-17

S

File No. 100496

Registered No. 55

Sex of Child Male Twin Triplet or other? No and Number in order of birth 1 Legitimate? Yes Date of Birth Mar 25 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Miles J. Slater  
RESIDENCE Malad  
COLOR White AGE AT LAST BIRTHDAY 36  
(Years)  
BIRTHPLACE England  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Rosale Jones  
RESIDENCE Malad  
COLOR White AGE AT LAST BIRTHDAY 32  
(Years)  
BIRTHPLACE Malad  
OCCUPATION Housewife

Number of child of this mother, including present birth, 2 Number of children of this mother now living, including present birth, 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 9 M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife (then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Fulton  
Thompson  
(Physician or midwife)

Given names added from a supplemental report.

Address .....  
Filed April 15 1922 W. H. M. D.  
Registrar Registrar

CHICKEN FOR BIRDS

1914

CHICKEN FOR BIRDS

CHICKEN FOR BIRDS

CHICKEN FOR BIRDS

CHICKEN FOR BIRDS

CHICKEN FOR BIRDS

PLACE OF BIRTH

STATE OF OHIO  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

10840

County

City

No.

Hospital

FULL NAME OF CHILD

Sex

Age

Only in case of illegitimate

Male

Female

FULL  
NAME

MOTHER

RESIDENCE

AT BIRTH

COLOR

AGE AT LAST  
DAY

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the \_\_\_\_\_ day of \_\_\_\_\_, 1914, at \_\_\_\_\_, \_\_\_\_\_, Ohio, and that the child was born alive, full term, and in good health, and that the mother was in good health and the birth was normal.

Witness my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 1914.

\_\_\_\_\_  
Physician or Midwife

\_\_\_\_\_  
Signature

WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

519-101-028-796

PLACE OF BIRTH

IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-9-3-17

S

County of... Kootenai...

City of... Roe Lake...

Registration District No. 123

File No. 100524

No. .... St.

Primary Registration District No. ....

Registered No. ....

Hospital Wardner Hosp. Kellogg Ida

FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? <u>1</u>	and	Number in order of birth <u>8</u>	Legiti- mate? <u>yes</u>	Date of Birth <u>1</u> <u>1</u> <u>1917</u> (Month) (Day) (Year)
--------------------------	---------------------------------------	-----	---	-----------------------------	--

FULL NAME <u>Halter Earling</u>	FATHER	FULL MAIDEN NAME <u>Clara Crossfield</u>	MOTHER
RESIDENCE <u>Roe Lake Idaho</u>		RESIDENCE <u>Roe Lake Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Wis</u>		BIRTHPLACE <u>Kansas</u>	
OCCUPATION <u>merchant</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 8 Number of children of this mother now living, including present birth 7

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

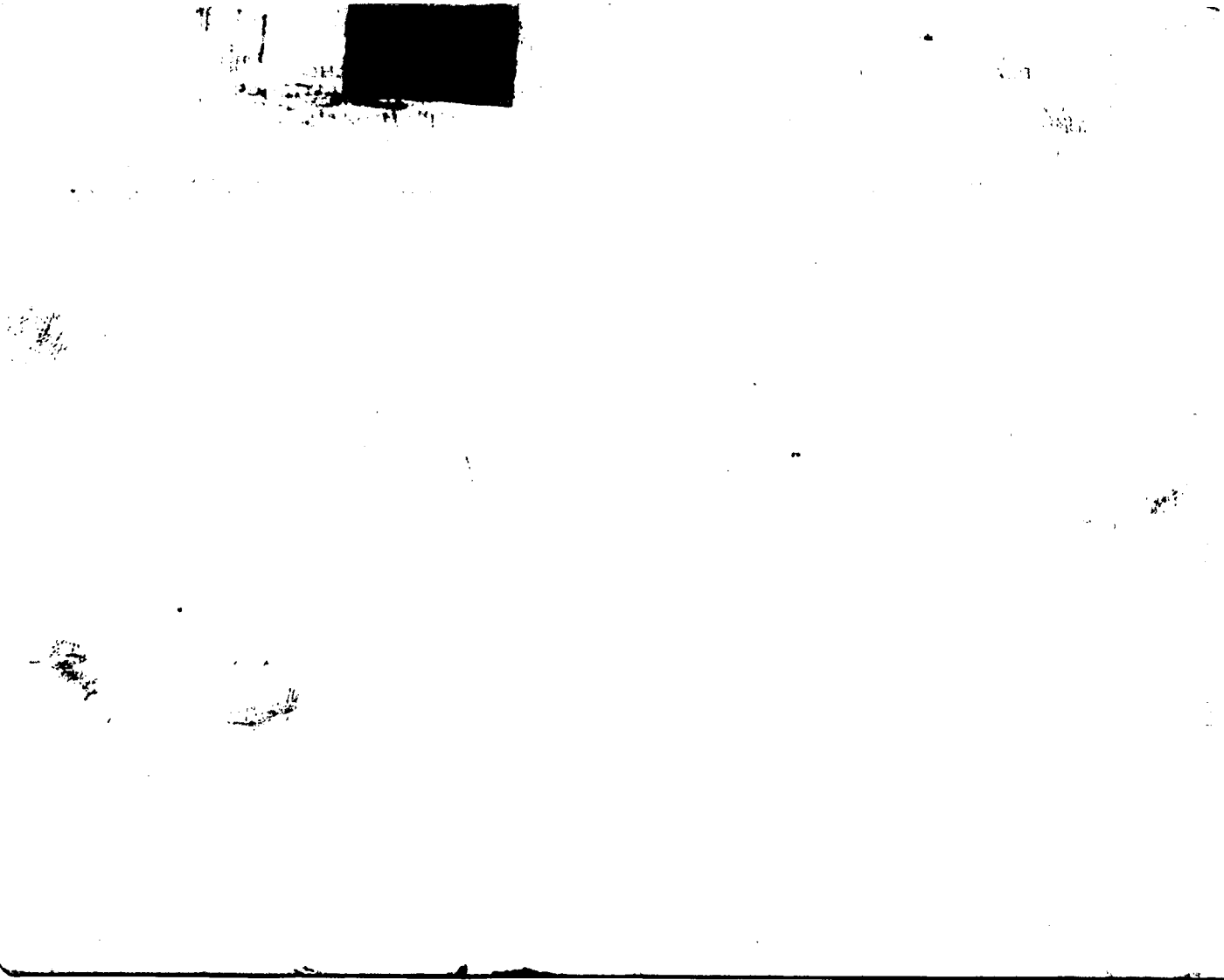
I hereby certify that I attended the birth of this child, who was ..... at ..... M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. C. Lindroy M.D.  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Kellogg Idaho  
Filed 3/23/1921  
Registrar E. E. Hardy





WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B. In case of more than one child a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

443-222-640-291

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-4-4-17

S

County of Shoshone

CERTIFICATE OF BIRTH

City of KelloggRegistration District No. 123File No. 100541

No. .... St.

Primary Registration District No. ....

Registered No. 22

Hospital .....

FULL NAME OF CHILD Mullis

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and (Number in order of birth 1)	Legiti- mate? <u>yes</u>	Date of Birth <u>3 22 1922</u> (Month) (Day) (Year)
----------------------------	---	---	-----------------------------	---

FATHER  
FULL NAME Jess B. MullisRESIDENCE KelloggCOLOR white AGE AT LAST  
BIRTHDAY 42  
(Years)BIRTHPLACE MissouriOCCUPATION minerMOTHER  
FULL MAIDEN NAME Elizabeth BrantleyRESIDENCE Kellogg IdahoCOLOR white AGE AT LAST  
BIRTHDAY 31  
(Years)BIRTHPLACE ArkansasOCCUPATION Housewife

Number of child of this mother, including present birth ..... Number of children of this mother now living, including present birth .....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was ..... at 10 A M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. D. Simpson

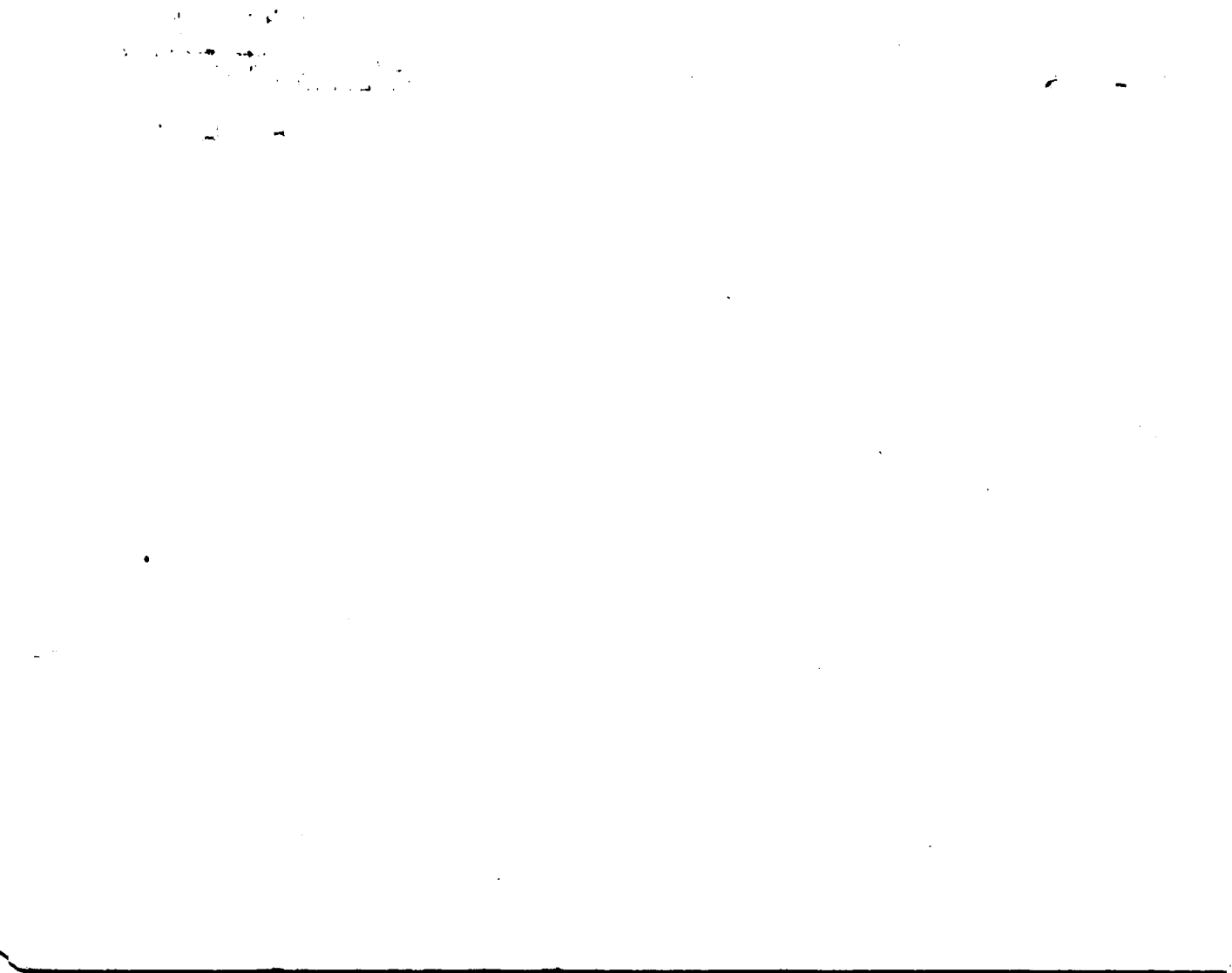
Physician or midwife

Given names added from a supplemental report.

Address Kellogg IdahoFiled 3/29/22

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **37812**  
Registered No. **17**

## 1. PLACE OF DEATH

County of Shoshone  
City of Heerzog

Registration District No. 123Primary Registration District No. 123(No. 123 St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Nellie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED single  
(Write the word.)

## 6. DATE OF BIRTH

March 23, 1922  
(Month) (Day) (Year)

## 7. AGE

— Yrs. — Mos. — ds.

IF LESS than 1 day  
how many — hrs.  
or — min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Heerzog Idaho

## 10. NAME OF FATHER

J. B. Mullies

## 11. BIRTHPLACE OF FATHER

(State or Country) Missouri

## 12. MAIDEN NAME OF MOTHER

Elizabeth Brantley

## 13. BIRTHPLACE OF MOTHER

(State or Country) Arkansas

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Mullies(Address) Heerzog, Idaho

## 15.

Filed 3/25/2219

E. E. Ford  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

March 23, 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/23 1922, to 3/23 1922

that I last saw him — alive on — 19 —and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH\* was as follows:

Still Born(Duration) — Yrs. — mos. — ds.Contributory  
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) W. C. Lindsay M. D.

3/23 1922 (Address) Heerzog, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death? —Former or usual residence —

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Heerzog, Idaho March 24, 1922

## 20. UNDERTAKER

## ADDRESS

M. C. Irons Heerzog

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

319-111-042-242

PLACE OF BIRTH

County of Twin Falls

City of Twin Falls

No. 403-2nd W. St.

Hospital \_\_\_\_\_

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
**RECEIVED**  
APR 21 1922  
BUREAU OF VITAL  
Registration District No. 37

Primary Registration District No. 1085

Form V. S. No. 11-C-25m-7-21-19

**S**

File No. 100592

Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>3</u> <u>11</u> <u>1922</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	----------------------------	---

FATHER  
FULL NAME Walter E. Carr  
RESIDENCE Twin Falls, Ida  
COLOR white AGE AT LAST BIRTHDAY 23 (Years)  
BIRTHPLACE Ida  
OCCUPATION laborer

MOTHER  
FULL MAIDEN NAME Goldie Vivian Bush  
RESIDENCE Twin Falls, Ida  
COLOR white AGE AT LAST BIRTHDAY 20 (Years)  
BIRTHPLACE Mammoth Ida  
OCCUPATION \_\_\_\_\_

Number of child of this mother, including present birth. 1 Number of children of this mother now living, including present birth. 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was streetborn, at 11 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. D. Weaver

(Physician or midwife)

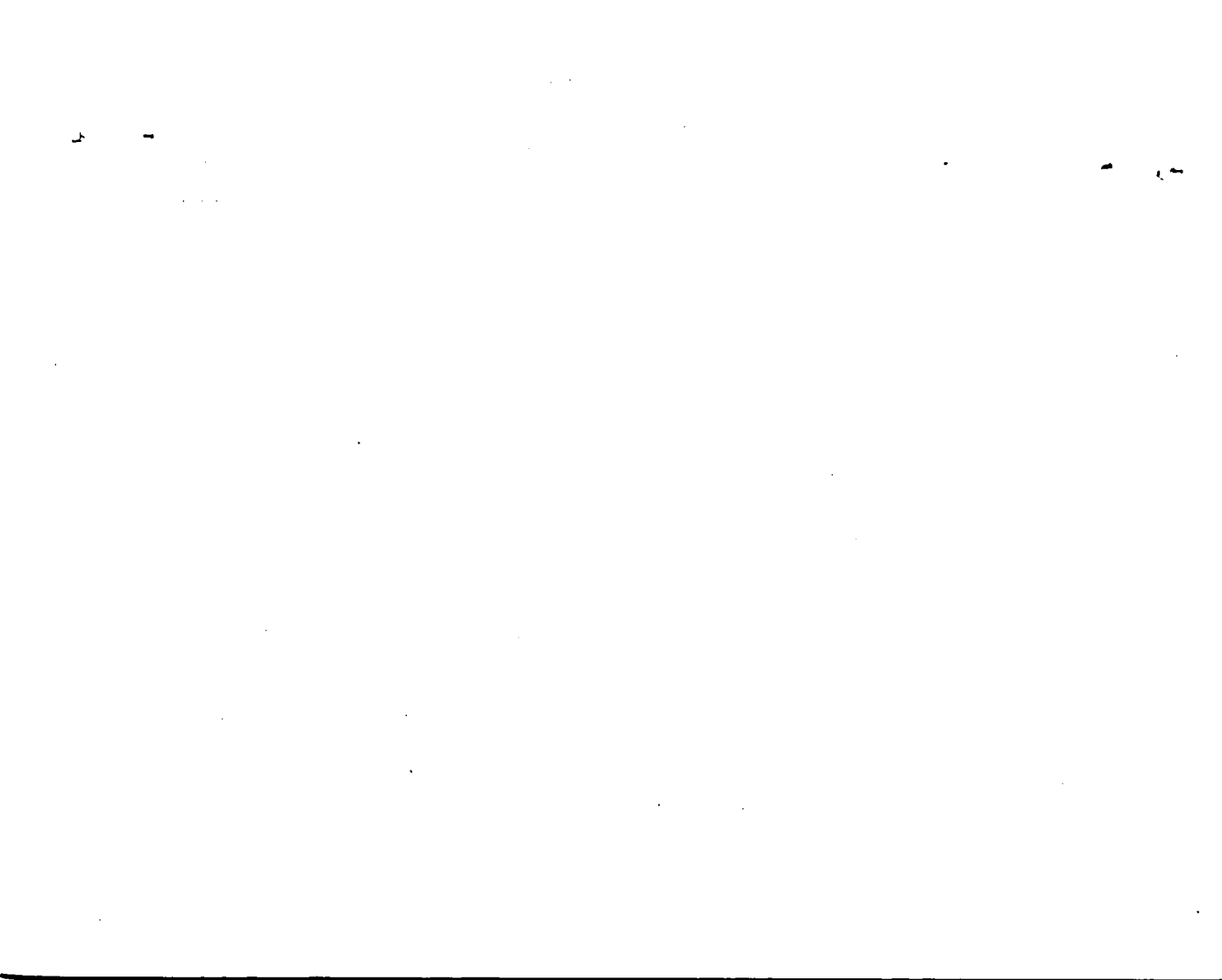
Given names added from a supplemental report.

Address Twin Falls

Filed April 9 19 22

Registrar

John J. Thorough  
Registrar



1. PLACE OF DEATH

County of *Devin*City of *"*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Carr*

## CERTIFICATE OF DEATH

Registration District No. *57*Registration District No. *1.6 85*

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *37821*  
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Male*

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED*Single*  
(Write the word.)

6. DATE OF BIRTH

*Mar 11 1922*  
(Month) (Day) (Year)

7. AGE

*0* Yrs. *0* Mos. *0* ds.IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

*Devin Tacer*

10. NAME OF FATHER

*W.E. Carr*

11. BIRTHPLACE OF FATHER

(State or Country)

*Penn.*

12. MAIDEN NAME OF MOTHER

*Goldie Vivian Bush*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*W.E. Carr*

(Address)

*Devin Tacer, Id.*

15.

Filed *April 9- 1922**John F. Brough*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Mar 10 1922*  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased ~~from~~*on 3/11 1922* tothat I last saw him *alive* ~~alive~~ *born dead* ~~born~~ *19*and that death occurred on the date stated above, at *10* M.

The CAUSE OF DEATH\* was as follows:

*Asphyxia*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

*C.D. Weaver* M.D.19 (Address) *Twin Falls*\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, ~~Self~~ *Self* or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

*Devin Tacer, Id.*

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

157-7



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

413-108-642-319  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Twin Falls  
City of Filer  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Registration District No. 38  
Hospital \_\_\_\_\_ Primary Registration District No. 2086  
File No. 100623  
Registered No. \_\_\_\_\_  
FULL NAME OF CHILD Not Named.  
(Certificate of no value without full name of child.)

Sex of Child <u>Boy</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Apr 8</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? Agno 3

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 2

FULL NAME <u>Joe Mallery</u>	FATHER	FULL MAIDEN NAME <u>Kate Larsen</u>	MOTHER
RESIDENCE <u>Filer Ida</u>		RESIDENCE <u>Filer Ida</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Mo</u>		BIRTHPLACE <u>Ida</u>	
OCCUPATION <u>Mechanic</u>		OCCUPATION <u>Hafr</u>	

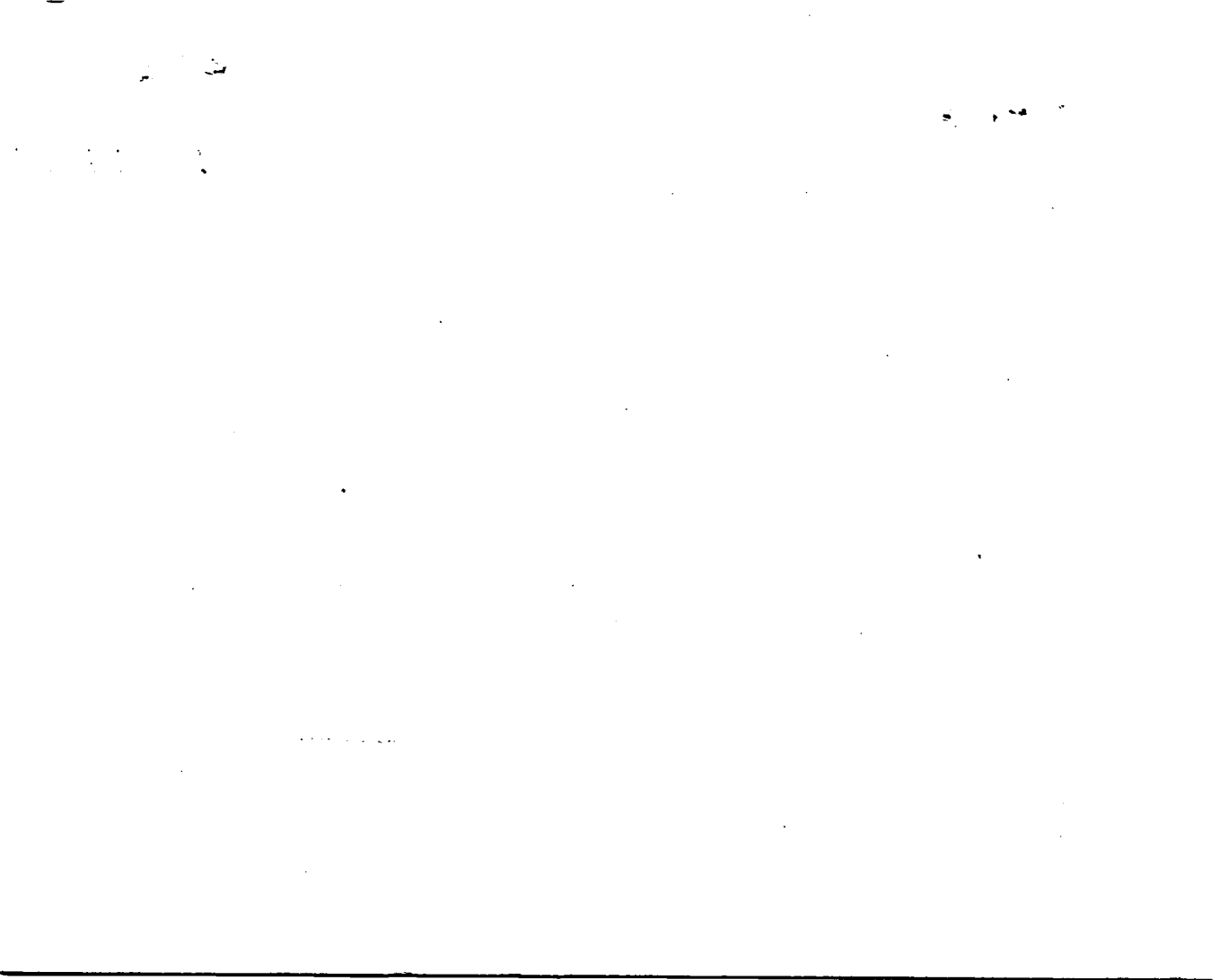
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_  
on the date above stated. (born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

(Signature) A. A. Newberry  
(Physician or midwife)  
Address Filer Ida  
Filed Apr 8 1922 A. A. Newberry  
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH

County of *Idaho Falls*

City of *Idaho Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Mallory*

RECEIVED

CERTIFICATE OF DEATH

Registration District No. *38*

Primary Registration District No. *2086*

(No. .... St.)

State of Idaho  
BOARD OF HEALTH

Bureau of Vital Statistics

File No. *37833*

Registered No. *37833*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Male*

4. COLOR OR RACE

*white*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

*Apr. 8 1922*  
(Month) (Day) (Year)

7. AGE

*Still Born*  
Yrs. .... Mos. .... ds.

IF LESS than 1 day  
how many .... hrs. or  
min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*J. F. Mallory*

11. BIRTHPLACE OF FATHER

(State or Country)

*Idaho*

12. MAIDEN NAME OF MOTHER

*Margaret Kate Garson*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*J. F. Mallory*

(Address)

*Idaho Falls*

Filed *Apr 8 1922*

*aan*

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Apr. 8 1922*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to *Apr 8* 191

that I last saw h. .... alive on ..... 191

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

*Still Born*

(Duration) Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) Yrs. .... mos. .... ds.

(Signed)

*A. A. Newberry*  
*File*

19 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days, State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

*Idaho Falls Cemetery*

DATE OF BURIAL

*Apr 9 1922*

20. UNDERTAKER

*H. Drake*

ADDRESS

*Idaho Falls*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers, who receive a definite salary*) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever.* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

155-121-001-168  
PLACE OF BIRTH.

Form V. S. No. 11—20m-7-28-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

County of AdaCity of BoiseNo. High School

Hospital

FULL NAME OF CHILD

RECEIVED

Registration District No. 2

File No.

100699

Primary Registration District No. 1004

Registered No.

Ronald Ray Dennison

Sex of Child

MaleTwin  
Triplet  
or other?  
(To be answered only in event of plural births)and { Number  
in order  
of birthLegiti-  
mate?YesDate of  
Birth5 - 21 - 1922

(Month) (Day) (Year)

FULL NAME

FATHER  
Alfred Ray Dennison

RESIDENCE

Reedsport, Oreg.

COLOR

WhiteAGE AT LAST  
BIRTHDAY23  
(Years)

BIRTHPLACE

Oregon

OCCUPATION

LumbermanFULL  
MAIDEN  
NAME

MOTHER

Leila Johansen

RESIDENCE

Reedsport, Oregon

COLOR

WhiteAGE AT LAST  
BIRTHDAY23  
(Years)

BIRTHPLACE

Nebraska

OCCUPATION

HousewifeNumber of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 11:30 P. M.  
on the date above stated. (Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Dr. J. Carl Hill  
Physician  
(Physician or midwife)

a. B.

Given names added from a supplemental report.

19

Address

Empire Bldg. Boise, Ida

Filed

5 - 31 - 1922

Registrar.

Registrar.

OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS

U. S. DEPARTMENT OF COMMERCE

WASHINGTON, D. C.

JUN 16 1922

BUREAU OF VITAL  
STATISTICS

Dear Madam:

Boise, Idaho, ..... 6/10 ..... 192...

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City Boise .....  
 { Street High School Park .....  
 { County .....  
 File Number ..... 100639 .....  
 Registration Dist. No. ....  
 Sex of Child ..... Male .....  
 Date of Birth May 21 ..... 1922 .....  
 Father Alfred Ray Dennison .....  
 Full Name .....  
 Mother Leila Lucille Joham .....  
 Full Maiden Name .....

I HEREBY CERTIFY that the child described herein has been named:

Donald Ray Dennison .....  
 Child's Name in Full

Leila L. Dennison .....  
 Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
ED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage  
legitimacy.

It enables the Public Health Nurse to make sure the child has  
protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are com-  
ed to furnish certified copies of certificates of birth, it is im-  
nt that the certificates be filed with the BUREAU OF VITAL STATIS-  
and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

359-1181003-864  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bannock MAY 26 1922  
City of Pocatello BUREAU OF VITAL STATISTICS  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. \_\_\_\_\_ File No. 18  
Hospital \_\_\_\_\_ Primary Registration District No. 161 Registered No. 4338

FULL NAME OF CHILD

Shelborn

(Certificate of no value without full name of child.)

Sex of Child <u>m</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>4-18</u> 192 <u>2</u> (Month) (Day) (Year)
-----------------------	---	-------	--------------------------------	-----------------------------	---

What bacteriocidal solution was used in eyes? ✓

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>Earl F. Leigh</u>	FULL MAIDEN NAME	<u>Helen Maurine Houghland</u>
RESIDENCE	<u>Pocatello</u>	RESIDENCE	<u>Pocatello</u>
COLOR	<u>wh</u>	COLOR	<u>wh</u>
AGE AT LAST BIRTHDAY	<u>24</u> (Years)	AGE AT LAST BIRTHDAY	<u>23</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Indiana</u>
OCCUPATION	<u>R. R. Shops</u>	OCCUPATION	<u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Subito at 5:02 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

\_\_\_\_\_, 19\_\_\_\_

Registrar.

(Signature)

L. C. Ray M.D.

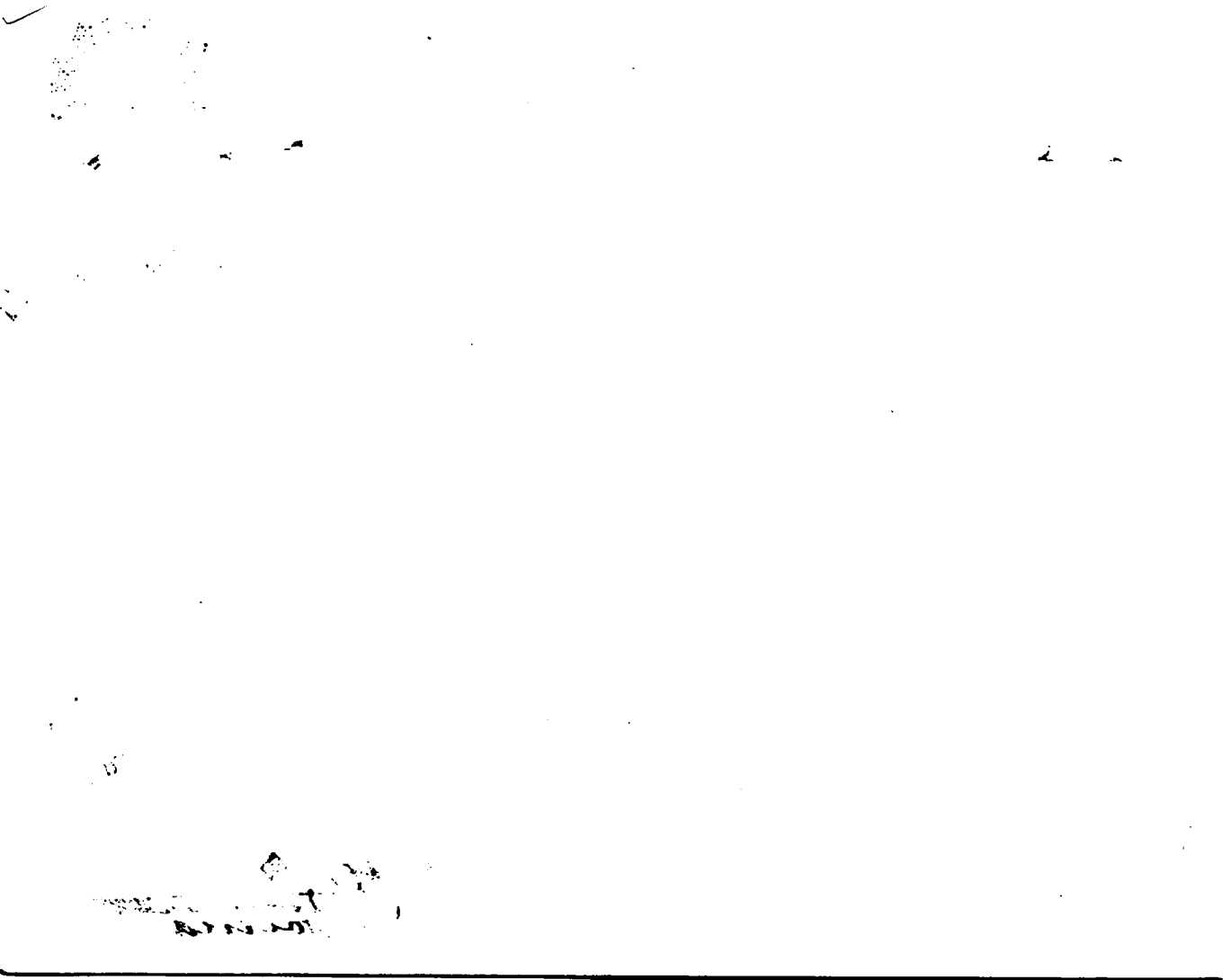
(Physician or midwife)

Address

Pocatello Idaho  
6/1 1922  
J. H. Houghland

Filed

Registrar.



FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Bannock*  
City of *Paratello*Registration District No. *28*Primary Registration District No. *2141*(No. *337 South 1st Ave* St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Infant Leigh*State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *37898*Registered No. *3820*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Infant*  
(Write the word.)

## 6. DATE OF BIRTH

*April 18 1922*  
(Month) (Day) (Year)

## 7. AGE

*Stillborn*  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

*Infant*

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Paratello Ida.*

## 10. NAME OF FATHER

*Earl Leigh*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Malade Ida.*

## 12. MAIDEN NAME OF MOTHER

*Helen Hoggland*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Indiana*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Earl Leigh*

(Address)

*Paratello*

## 15.

Filed

*4/14**1922**W. H. Hoggland*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*April 18 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*19* to *Apr 18 1922*that I last saw him alive on *19*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH\* was as follows:

*Cord around neck stopping  
circulation  
Dead in utero about 48 hours*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*4/18 1922*

(Address)

*J. C. Ray* M. D.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Mountain View Cem*

## DATE OF BURIAL

*Apr 19 1922*

## 20. UNDERTAKER

*Schumacher & Hall*

## ADDRESS

*Paratello*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

44-1041003-000  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bannock  
City of Porter  
No. 1748 St. Porter Registration District No. 28 File No. 100776  
Hospital Porter Primary Registration District No. 2161 Registered No. 4349  
FULL NAME OF CHILD Mormota  
(Certificate of no value without full name of child.)

Sex of Child M Twin Triplet or other? None and Number in order of birth 1 Legitimate? Yes Date of birth 1-4 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER  
FULL NAME R. Mormota  
RESIDENCE Porter Idaho  
COLOR Ja AGE AT LAST BIRTHDAY 46 (Years)  
BIRTHPLACE Japan  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Shige  
RESIDENCE Porter Idaho  
COLOR Ja AGE AT LAST BIRTHDAY 32 (Years)  
BIRTHPLACE Japan  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

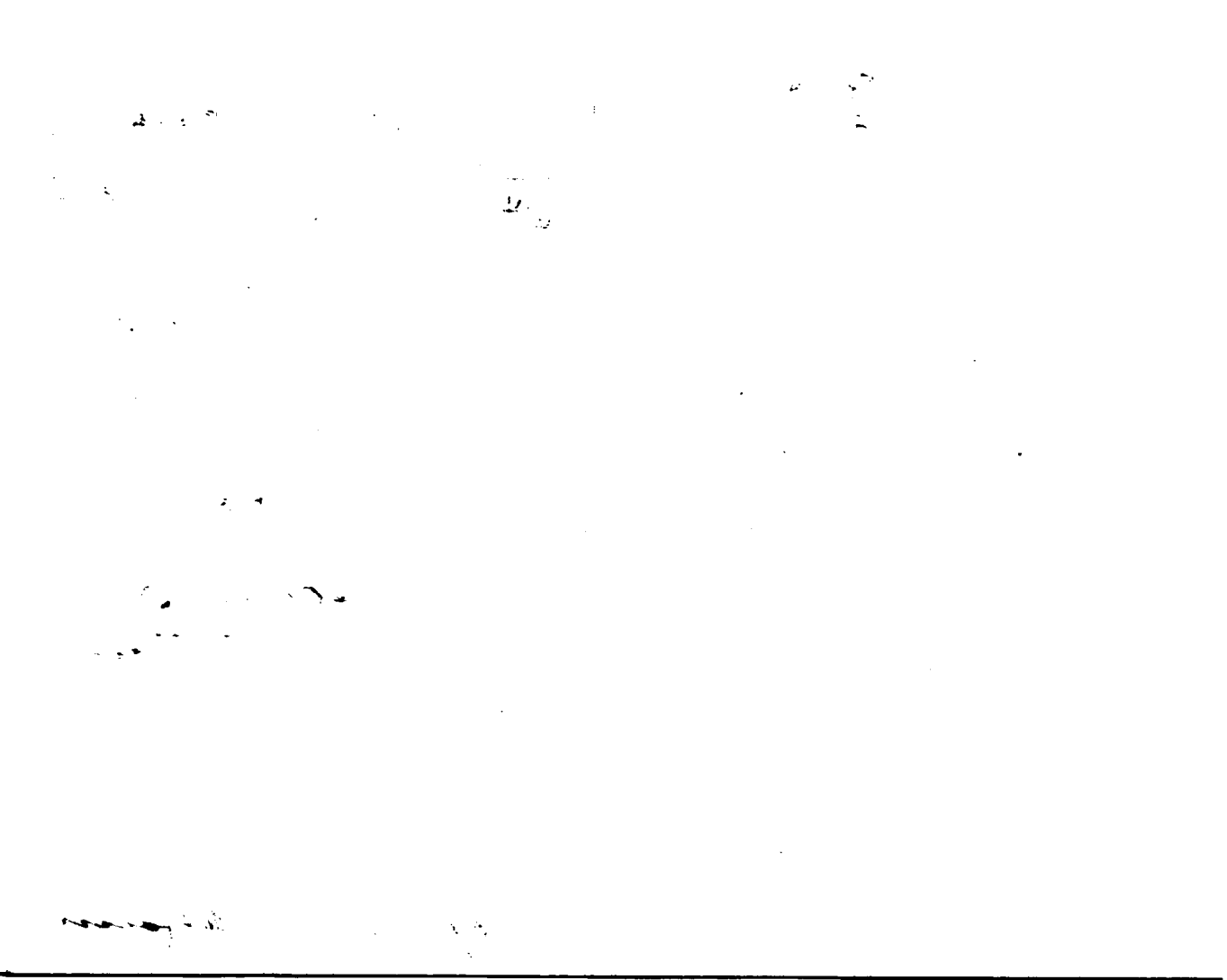
I hereby certify that I attended the birth of this child, who was Stillborn at 6 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. H. ...  
Physician  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Porter  
Filed 5/1 1922 J. Young  
Registrar.



FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

Bannock County, Idaho  
City of Pocatello  
POCATELLO, IDAHORECEIVED  
CERTIFICATE OF DEATH

Registration District No. 28

Bureau of Vital Statistics  
Registration District No. 2161

(No. State of Idaho St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 44708

Registered No. 35708

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Marimato

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Jan 4 1922  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Pocatello, Idaho

10. NAME OF FATHER

R. Marimato

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

S. Marimato

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. Marimato

(Address)

Tighee, Idaho

15.

Filed Jan 4 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 4 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH\* was as follows:

Steel bar

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

F. J. [Signature] M. D.

1/4 1922 (Address) Pocatello, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem. Pocatello Jan 4 1922

20. UNDERTAKER

H. L. McHAN

ADDRESS

POCATELLO, IDAHO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.*; *Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

855-218-006-133

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S

County of Pinghang JUN 7 1922

City of Shelley BUREAU OF VITAL STATISTICS

Registration District No. 121

File No. 100869

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_ Primary Registration District No. 2194 Registered No. 214

FULL NAME OF CHILD Mary Greta Henderson

Sex of Child <u>Female</u>	Twin Triplet or other? <u>No</u>	and	Number in order of birth _____	Legiti mate? <u>Yes</u>	Date of Birth <u>Mar 18</u> 19 <u>22</u>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

FULL NAME FATHER George Washington Henderson

FULL MAIDEN NAME MOTHER Lilie Allen

RESIDENCE Shelley

RESIDENCE Shelley Ida.

COLOR White AGE AT LAST BIRTHDAY 31 (Years)

COLOR White AGE AT LAST BIRTHDAY 25 (Years)

BIRTHPLACE Salt Lake City Utah

BIRTHPLACE Victor Idaho

OCCUPATION Farmer

OCCUPATION Housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 9 A. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

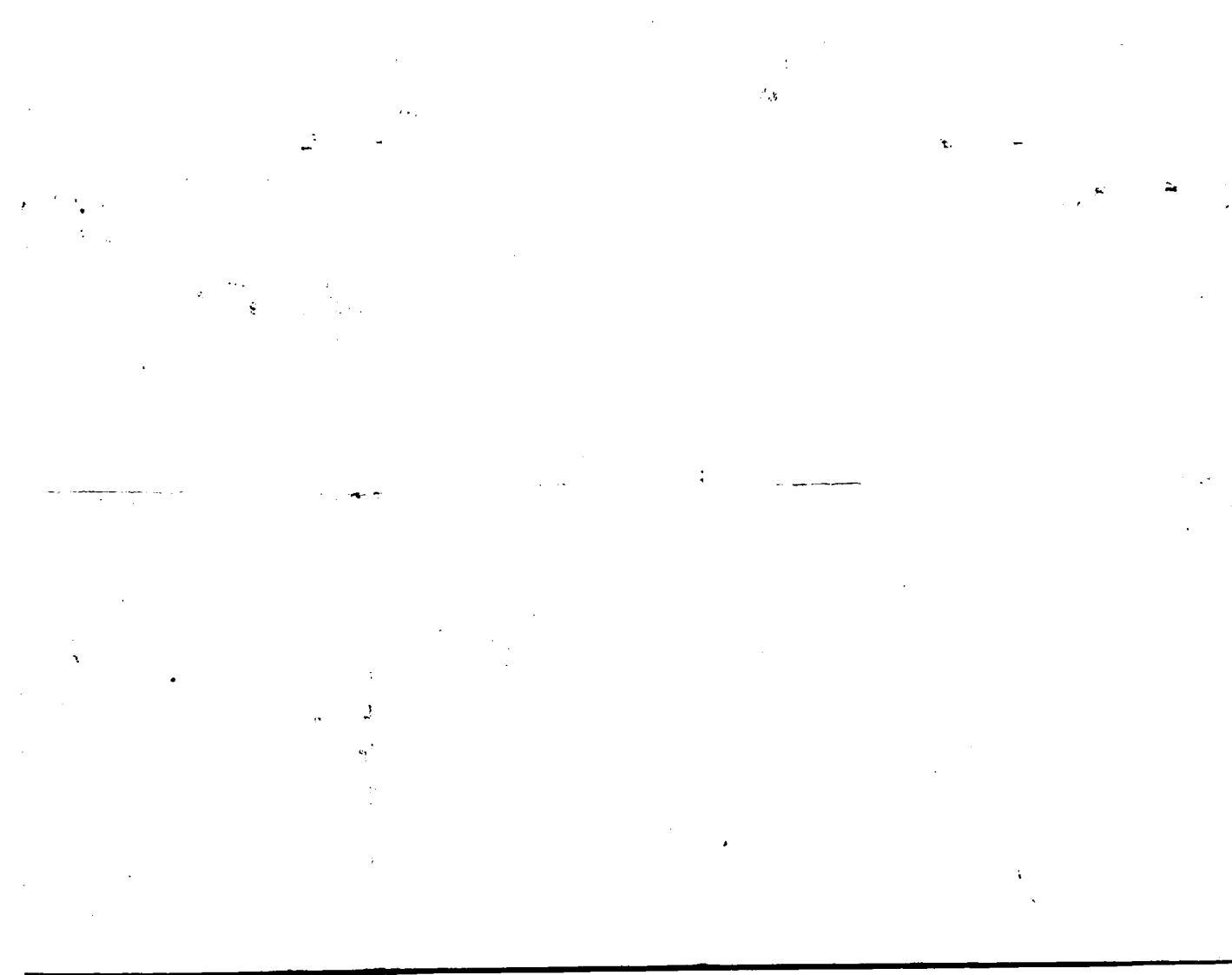
(Signature) G. F. Ebert  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Shelley Ida.

Filed May 26 1922 Mr. Halsey E. Pattee  
Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-20. M. 1-19.

## 1. PLACE OF DEATH

County of Bingham Registration District No. 121  
City of Shelley BUREAU OF VITAL STATISTICS Registration District No. 2194 St. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Mary Iota Henderson

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 37947  
Registered No. 84

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant  
(Write the word.)

6. DATE OF BIRTH

Mar. 18 1922  
(Month) (Day) (Year)

7. AGE

Stillborn IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

Shelley Ida  
(State or Country)

10. NAME OF FATHER

Mrs. Washington Henderson

11. BIRTHPLACE OF FATHER

Salt Lake City Utah  
(State or Country)

12. MAIDEN NAME OF MOTHER

Lila Allen

13. BIRTHPLACE OF MOTHER

Victor Idaho  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George W. Henderson  
(Address) Shelley Idaho

15. Filed

May 14 1922 Mrs. Helen E. Paton  
Local Registrar

16. DATE OF DEATH

Mar. 18 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 18 1922, to Mar. 18 1922,  
that I last saw him alive on Stillborn 19...

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn  
7 months

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

J. P. Egbert

M. D.

1922 (Address) Shelley Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

\_\_\_\_\_ 19 \_\_\_\_\_

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

393-117,006-849

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C—Rev. 3-17

S

County of Bingham JUN 7 1922

City of Bekfor BUREAU OF VITAL STATISTICS

Registration District No. 121

File No. 100878

No. near fed yard

Primary Registration District No. 1007

Registered No. 223

Hospital

FULL NAME OF CHILD Unnamed Lillian

Sex of Child <u>M</u>	Twin Triplet or other <u>X</u>	and (Number in order of birth <u>X</u> )	Legitimate? <u>Yes</u>	Date of Birth <u>May 17 1922</u> (Month) (Day) (Year)
-----------------------	--------------------------------	--	------------------------	--

FULL NAME Martin Lillian FATHER  
RESIDENCE Bekfor near fed yard  
COLOR W AGE AT LAST BIRTHDAY 36 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Laborm

FULL MAIDEN NAME Parah Hurst MOTHER  
RESIDENCE Bekfor near fed yard  
COLOR W AGE AT LAST BIRTHDAY 33 (Years)  
BIRTHPLACE Oregon  
OCCUPATION Housewife

Number of child of this mother, including present birth. 8 Number of children of this mother now living, including present birth. 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still born on the date above stated.

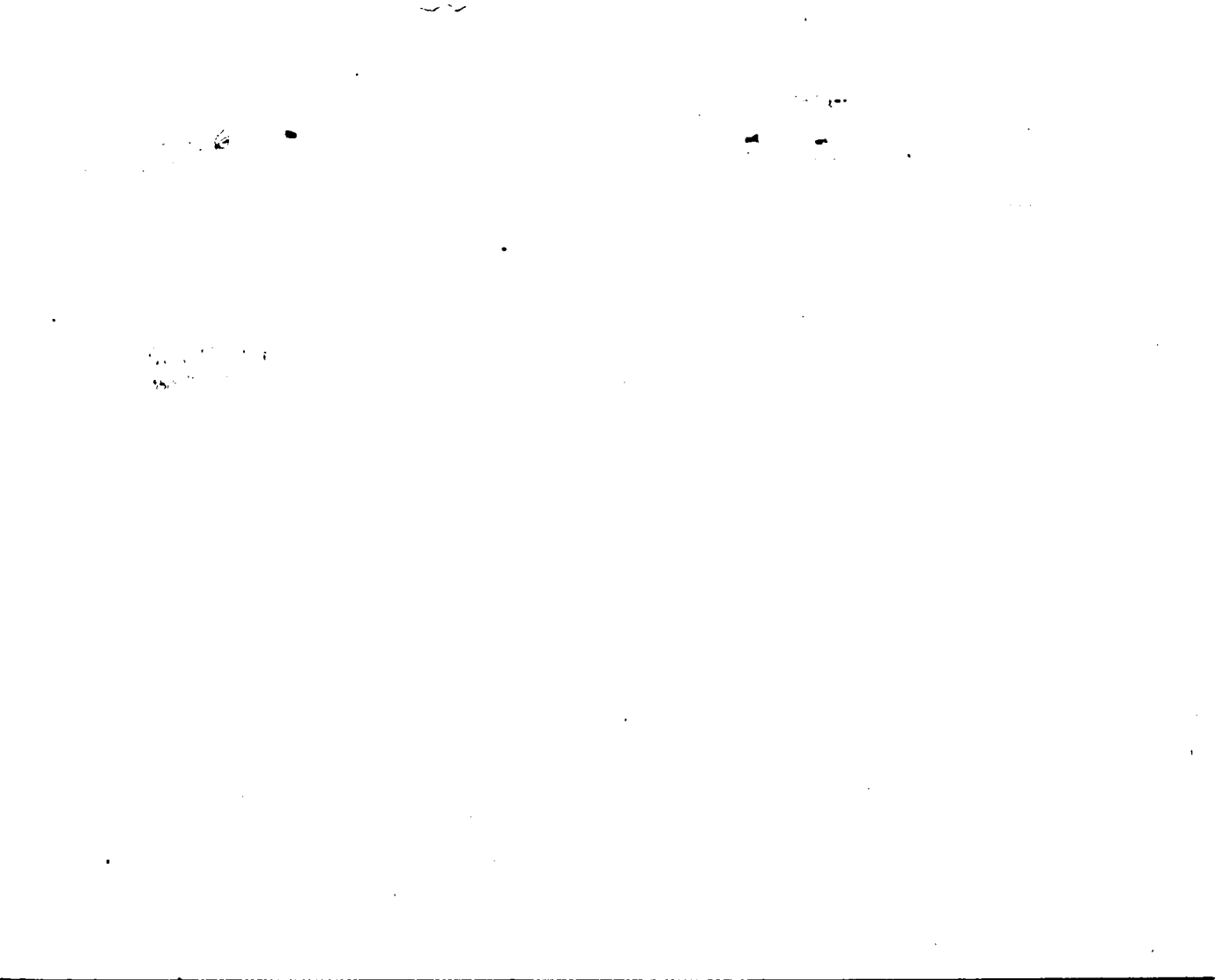
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. Adams (Born alive or stillborn) 40 10-a

Given names added from a supplemental report.

(Physician or midwife)

Address Blair 1st St. & 1st St.  
Filed June 1 1922  
Registrar W. H. Adams



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bingham Registration District No. 187  
City of Blackfoot Primary Registration District No. 1007  
(No. West Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

## 2. FULL NAME

Lillya

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 37946Registered No. 82

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

May 17 1922  
(Month) (Day) (Year)

## 7. AGE

Still born

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

None

## 9. BIRTHPLACE

(State or Country)

Blackfoot Ida

## 10. NAME OF FATHER

Martin C. Lillya

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Sarah Hurst

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Martin C. Lillya

(Address)

Blackfoot

## 15. Filed

May - 17 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 17 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

May 17 1922 to May 17 1922

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

J. S. Davis M. D.

19\_\_\_\_ (Address) Blackfoot Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. \* In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Grove City Cemetery 5/17 1922

## 20. UNDERTAKER

## ADDRESS

E. L. Egli Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

219-230-009-666  
PLACE OF BIRTH

RECEIVED  
JUN 5 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bonner **BUREAU OF VITAL STATISTICS**  
City of Sandpoint **CERTIFICATE OF BIRTH**  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. \_\_\_\_\_ File No. 100905  
Hospital City Primary Registration District No. 2155 Registered No. \_\_\_\_\_  
FULL NAME OF CHILD Still born

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? _____	and	Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth <u>5/30/22</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FULL NAME <u>FATHER</u> <u>Harry David Barr</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Maude Woodward</u>
RESIDENCE <u>Sagle</u> <u>Ida.</u>	RESIDENCE <u>Sagle</u> <u>Ida.</u>
COLOR <u>white</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>40</u> (Years)	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Kansas</u>	BIRTHPLACE <u>Mo.</u>
OCCUPATION <u>laborer</u>	OCCUPATION <u>Haw.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 9 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

Give names added from a supplemental report.

\_\_\_\_\_, 19\_\_\_\_

Registrar.

(Signature)

W. R. Woodward

Physician  
(Physician or midwife)

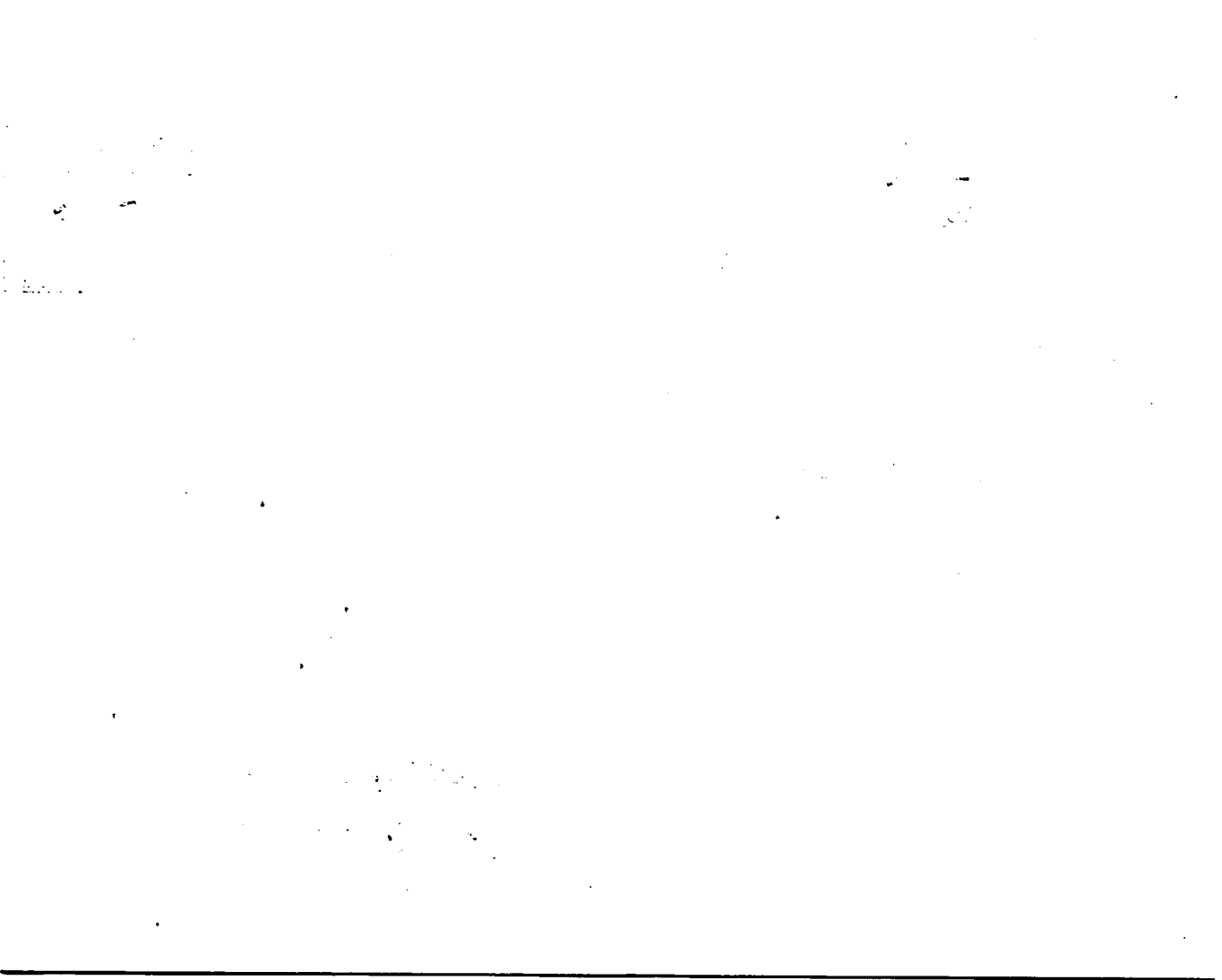
Address

Sagle

Filed

June 2 1922

Registrar.



FORM V. S. No. 5-25 M. 1-19.

RECEIVED  
JUN 5 1922

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 37968

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH Bureau of Vital Statistics  
County of Banner Registration District No. \_\_\_\_\_  
City of Sandpoint (No. \_\_\_\_\_, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)6. DATE OF BIRTH May 30/22  
(Month) (Day) (Year)7. AGE stillborn IF LESS than 1 day  
how many hrs. or min.?  
Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE Idaho  
(State or Country)10. NAME OF FATHER Harry David Barr11. BIRTHPLACE OF FATHER Kan.  
(State or Country)12. MAIDEN NAME OF MOTHER Maude Woodward13. BIRTHPLACE OF MOTHER Mo  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_  
(Address) \_\_\_\_\_15. Filled June 2 1922 Noted Local Registrar  
copy

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 30/22  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from stillborn 19\_\_\_\_, to 19\_\_\_\_, that I last saw him alive on 19\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_ M.  
The CAUSE OF DEATH\* was as follows:  
nephritis in the mother(Duration) \_\_\_\_ Yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory (Secondary)(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) M. F. Woodward M. D.  
5/31/22 (Address) Sandpoint

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ days. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL Sandpoint DATE OF BURIAL 5/30/22 19\_\_\_\_20. UNDERTAKER NONE ADDRESS \_\_\_\_\_

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

693-117-010-815

19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of BonnevilleCity of Ida FallsNo. 15th St.Hospital Peoples

FULL NAME OF CHILD

## CERTIFICATE OF BIRTH

Registration District No. 73File No. 100941Primary Registration District No. 2157Registered No. 9FWilliams

Sex of Child <u>Male</u>	Twin <input type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/> and <input type="checkbox"/> Number in order of birth <input type="checkbox"/> (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of Birth <u>Feb 17</u> 19 <u>22</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

FATHER  
FULL NAME Ralph WilliamsRESIDENCE Ida FallsCOLOR white AGE AT LAST BIRTHDAY 24 (Years)BIRTHPLACE WarsawOCCUPATION clerkMOTHER  
FULL MAIDEN NAME Marie HansonRESIDENCE sameCOLOR white AGE AT LAST BIRTHDAY 23 (Years)BIRTHPLACE Weston, IdaOCCUPATION H.W.Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born dead at 6 a M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Jabez M. Smith MD

(Physician or midwife)

Given names added from a supplemental report.

Address Idaho FallsFiled May 2 1922 C. J. Fennell

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Barnesville*  
City of *Ida Falls*Registration District No. *1*Primary Registration District No. *1 V*File No. *37557*Registered No. *37557*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Baby Williams*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*w*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

*July*  
(Month)*17*  
(Day)*1922*  
(Year)

## 7. AGE

*0* Yrs. *0* Mos. *0* ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*R. B. Williams*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Utah*

## 12. MAIDEN NAME OF MOTHER

*Marie Hansen*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*R. B. Williams*

(Address)

*Ida Falls*

## 15. Filed

*Mar 9**1922**W. J. Williams*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Feb*  
(Month)*19*  
(Day)*22*  
(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*19* to *19*that I last saw him *alive* on *Feb 17* *1922*and that death occurred on the *date* stated above, at *Idaho Falls* M.

The CAUSE OF DEATH\* was as follows:

*Still born*(Duration) Yrs. mos. ds.  
Contributory (Secondary) *Influenza & mother*  
*a pneumonia*(Duration) Yrs. mos. ds.  
(Signed) *W. J. Williams* M. D.*7/18 1922* (Address) *Idaho Falls, Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Ida Falls*

## DATE OF BURIAL

*7/18 1922*

## 20. UNDERTAKER

*G. E. Woodward*

## ADDRESS

*Ida Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

239-119-023  
795

PLACE OF BIRTH

RECEIVED  
MAY 23 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Yam

City of New Plymouth

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

File No. 101214

Hospital \_\_\_\_\_

Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>2 19 1922</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	-----------------------------	---

What bacterioidal solution was used in eyes? none

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 4

FATHER  
FULL NAME U. G. Bradley  
RESIDENCE New Plymouth  
COLOR white AGE AT LAST BIRTHDAY 36 (Years)  
BIRTHPLACE Philips Co Kans  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Bessie Greenfield  
RESIDENCE New Plymouth  
COLOR white AGE AT LAST BIRTHDAY 35 (Years)  
BIRTHPLACE Philips Co Kans  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 1 a M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) R. T. Cummings

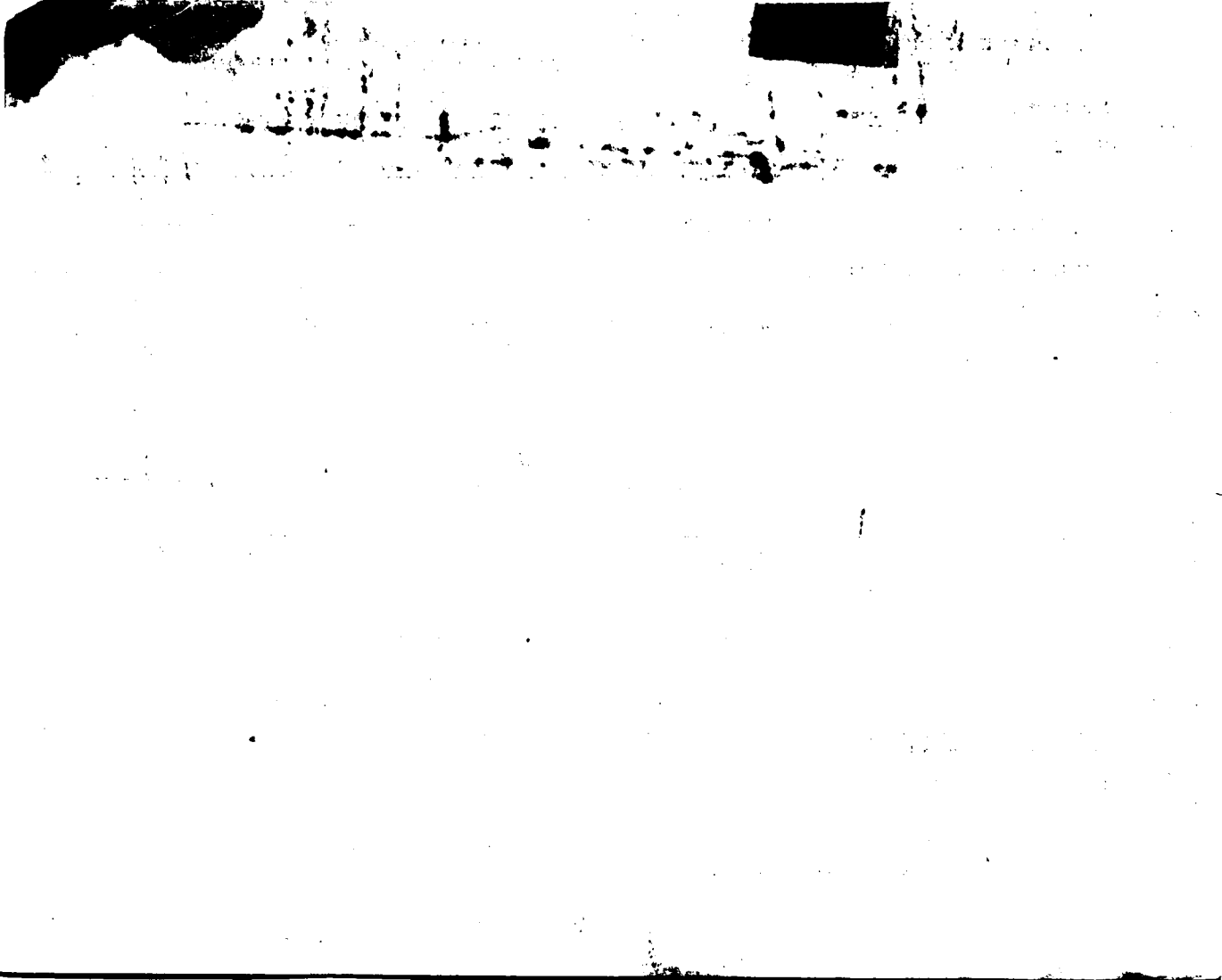
(Physician or midwife)

Give names added from a supplemental report.

Address Emmett

Filed 4/20/1922 J. L. Reynolds Registrar.

Registrar.



819-120-025-342

RECEIVED

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

JUN 6 1922

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of IdahoBUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

S

City of PrunigvilleRegistration District No. 103File No. 101276

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 1001Registered No. 26

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Stillborn

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>May 20 - 22</u> (Month) (Day) (Year)
--------------------------	------------------------------	-----------	--------------------------------	------------------------	--

FULL NAME <u>James Oscar Harris</u>	FATHER
RESIDENCE <u>Prunigville Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Oregon</u>	
OCCUPATION <u>Rancher</u>	

FULL MAIDEN NAME <u>Emily Cook</u>	MOTHER
RESIDENCE <u>Prunigville Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth <u>5</u>	Number of children of this mother now living, including present birth <u>3</u>
--	--

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 11 P. M.  
on the date above stated. (Born alive or stillborn)

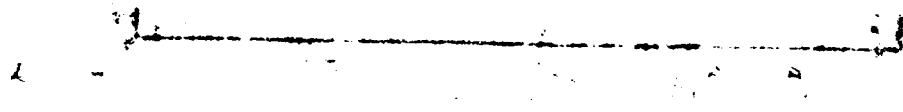
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]  
(Physician or midwife)

Given names added from a supplemental report.

Address Prunigville Ida  
Filed June 1 1922 G. B. Stockton  
Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of IdahoCity of Brangerville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ralph Harris

JUN 6 1922

District No.

703

Registration District No.

2181

St.)

File No.

Registered No.

38037

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

May 20 1922  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Brangerville

10. NAME OF FATHER

Wesley Harris

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Emily Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Brangerville Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ralph Harris

(Address)

Brangerville Idaho

15.

Filed June 1 192258 Street

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

189-6

16. DATE OF DEATH

May 20 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillbirth  
transverse presentation

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) B. Chipman M. D.527 1922 (Address) Brangerville Idaho

\*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pratt View

DATE OF BURIAL

57.21.1922

20. UNDERTAKER

E. S. Hancock

ADDRESS

Brangerville

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

349-109-026-844

Form V. S. No. 11-20m-7-24-19

PLACE OF BIRTH

RECEIVED  
JUN 8 1922

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

101306

County of Jefferson

City of Pocatello

Registration District No. 98

File No.

No.

St.

Hospital home

Primary Registration District No. 2176

Registered No. 180

FULL NAME OF CHILD

Sex of Child m

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)and  
Number  
in order  
of birth

Legitimate? Yes

Date of Birth 2/9/22

(Month)

(Day)

19

(Year)

FULL NAME

FATHER

Dwight Curtis

RESIDENCE

Pocatello

COLOR

White

AGE AT LAST BIRTHDAY 42

(Years)

BIRTHPLACE

Cedarwood St

OCCUPATION

Farmer

FULL MAIDEN NAME

MOTHER

Lore Humphrey

RESIDENCE

Pocatello

COLOR

White

AGE AT LAST BIRTHDAY 23

(Years)

BIRTHPLACE

Pocatello Utah

OCCUPATION

home

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

5-10

19

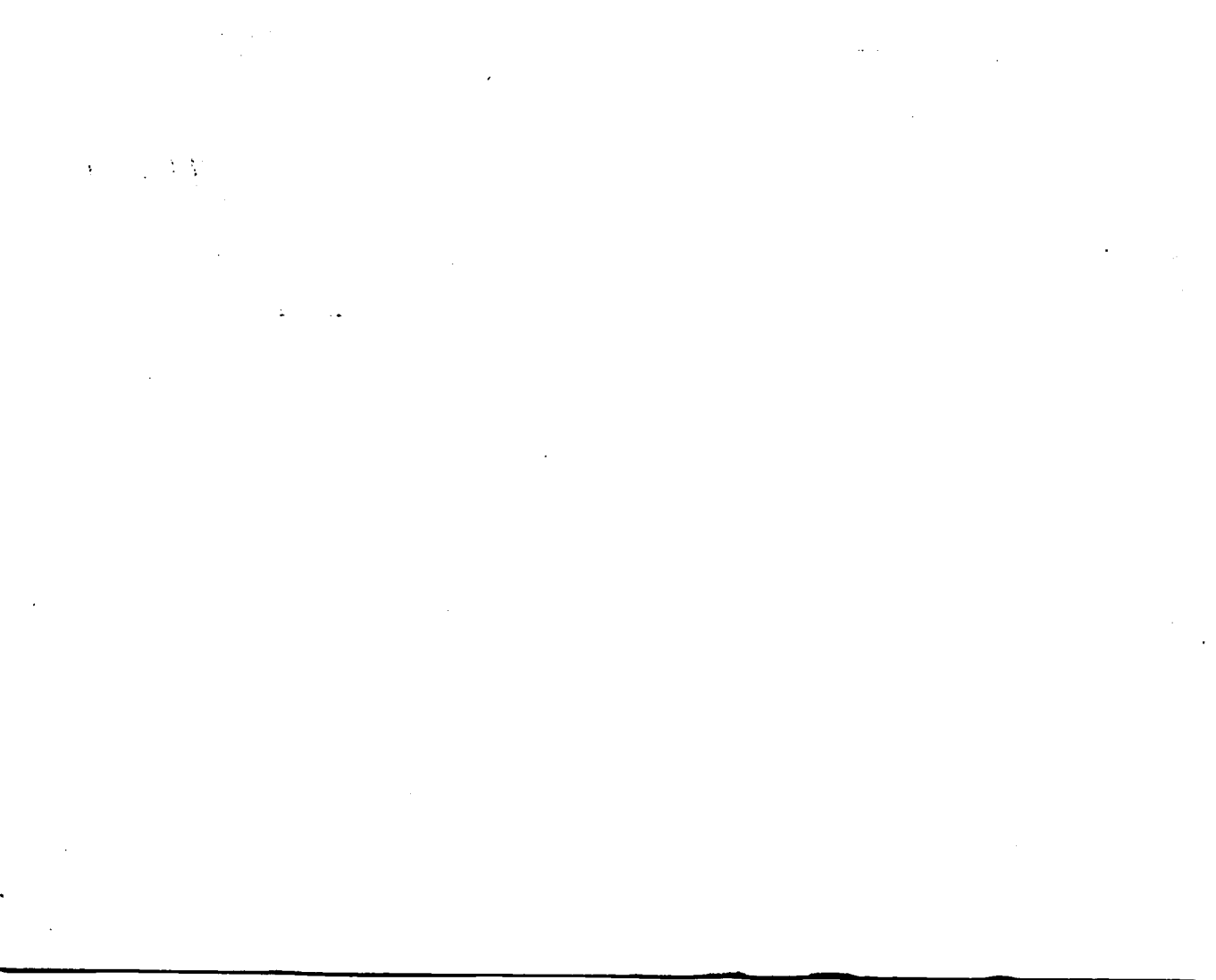
22

Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.





WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

556-113-028-275  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
RECEIVED  
MAY 23 1922  
CERTIFICATE OF BIRTH

S

County of Kootenai  
City of Corneal Allen  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 30 File No. 101374  
Hospital \_\_\_\_\_ Primary Registration District No. 105-1 Registered No. 1289  
FULL NAME OF CHILD 2nd. Named. Newton  
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>April 13</u> 192 <u>2</u> (Month) (Day) (Year)
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What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 3 ... Number of child of this mother now living, including present birth... 2 ...

FATHER		MOTHER	
FULL NAME <u>Albert Newton</u>	FULL MAIDEN NAME <u>Ruth Spregue</u>	FULL NAME <u>Albert Newton</u>	FULL MAIDEN NAME <u>Ruth Spregue</u>
RESIDENCE <u>Corneal Allen</u>	RESIDENCE <u>Corneal Allen</u>	RESIDENCE <u>Corneal Allen</u>	RESIDENCE <u>Corneal Allen</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>House wife</u>	OCCUPATION <u>Laborer</u>	OCCUPATION <u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Dead at 2:30 P.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. D. Drema

(Physician or midwife)

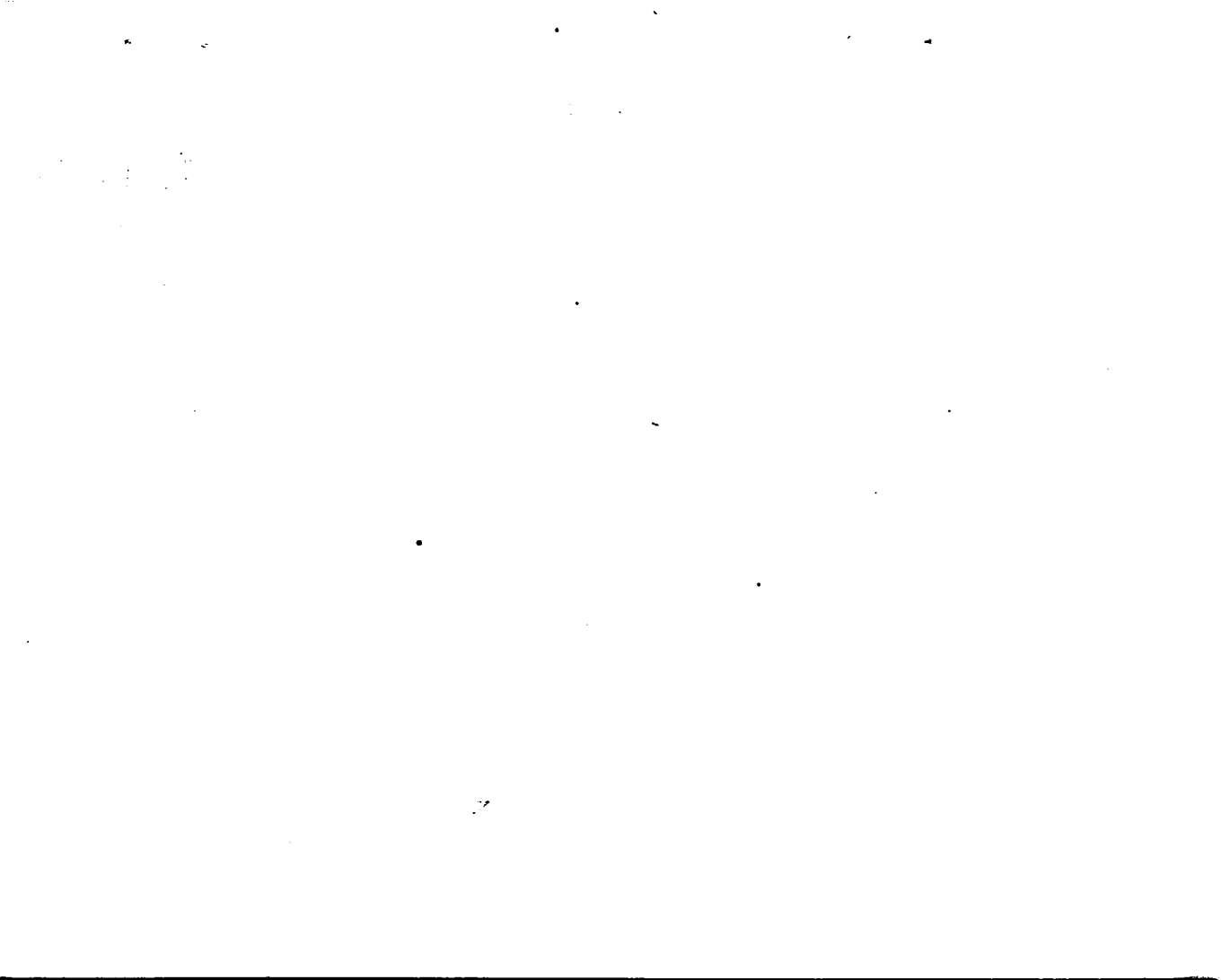
Give names added from a supplemental report.

Address Corneal Allen

Filed 5/10 1922 D. D. Drema

Registrar.

Registrar.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **38120**  
Registered No. **1058**

## 1. PLACE OF DEATH

County of Kootenai Registration District No. 30  
City of Coeur d'Alene (No. 1057) St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

not Named Newton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

April 13 1922  
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.

IF LESS than 1 day  
how many — hrs.  
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Albert Newton

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Ruth Spreng

13. BIRTHPLACE OF MOTHER

(State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Newton

(Address) Coeur d'Alene

15.

Filed May 4 1922 L.H. Drenna  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 13 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

— 19 — to — 19 —

that I last saw him — alive on — 19 —

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH\* was as follows:

Premature Birth

(Duration) — Yrs. — mos. — ds.

Contributory  
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) L.H. Drenna M. D.

4/14 1922 (Address) Coeur d'Alene

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

802 Young St

4/14 1922

20. UNDERTAKER

ADDRESS

Albert Newton Coeur d'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

249-130-028-314  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

101389

County of Lincoln  
City of Coeur d'Alene  
No. 205 Indiana St. Registration District No. 30 File No. \_\_\_\_\_  
Hospital Reed Primary Registration District No. 1057 Registered No. 1279  
FULL NAME OF CHILD Harold Eugene Smith

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other <u>one</u> } and { Number in order of birth <u>one</u>	Legitimate? <u>yes</u>	Date of birth <u>March 30</u> 1922 (Month) (Day) (Year)
--------------------------	--	------------------------	--

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth... 2 Number of child of this mother now living, including present birth... 2

FATHER		MOTHER	
FULL NAME <u>Harold Edward Smith</u>	FULL MAIDEN NAME <u>Della Ethel Cameron</u>		
RESIDENCE <u>Coeur d'Alene Id.</u>	RESIDENCE <u>Coeur d'Alene Id.</u>		
COLOR <u>White</u>	COLOR <u>American</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)	AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>St. Charles, Mo.</u>	BIRTHPLACE <u>Rock Island Ill.</u>		
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Child born at 4 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

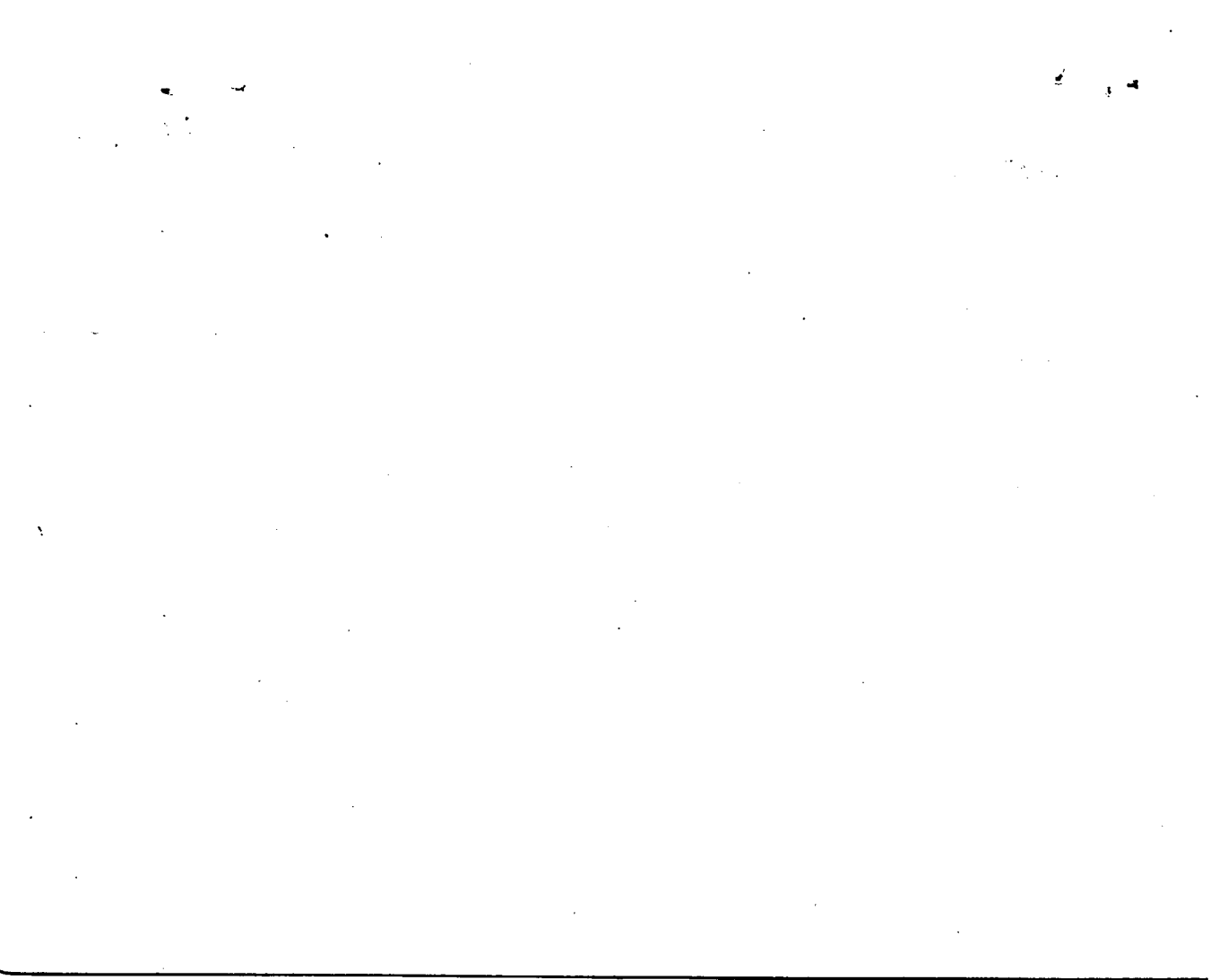
(Signature) W. H. Keadle  
Physician  
(Physician or midwife)

Address Coeur d'Alene Idaho

Filed 5/10 1922 L. H. Green

Registrar.

Registrar.



FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Kootenai*  
City of *Coeur d'Alene*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *20*Primary Registration District No. *1037*(No. *205 Indiana* St.)

## 2. FULL NAME

*Shirborn Smith*State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *37676*Registered No. *1039*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*M.*

## 4. COLOR OR RACE

*W.*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*single*

(Write the word.)

## 6. DATE OF BIRTH

*March 30 1922*  
(Month) (Day) (Year)

## 7. AGE

*0* Yrs. *0* Mos. *0* ds.IF LESS than 1 day  
how many *0* hrs.  
or *0* min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) *Idaho*

## 10. NAME OF FATHER

*W. E. Smith*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Mo.*

## 12. MAIDEN NAME OF MOTHER

*Deel Ethel Corman*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Iowa*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. E. Smith*

(Address)

## 15.

Filed *April 5 1922**1922*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Mich 29 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*19* to *19*  
that I last saw him *alive* on *19*  
and that death occurred on the date stated above, at *M.*  
The CAUSE OF DEATH\* was as follows:*Shirborn*(Duration) *Yrs.* *mos.* *ds.*Contributory  
(Secondary)(Duration) *Yrs.* *mos.* *ds.*(Signed) *J. H. Koedeen**3/30 1922* (Address) *Coeur d'Alene, Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *Yrs.* *mos.* *days.* In the State *Yrs.* *mos.* *days.*

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Forest Cem. Coeur d'Alene*

## DATE OF BURIAL

*3-31 1922*

## 20. UNDERTAKER

*C. Carsey*

## ADDRESS

*Co. Alene.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

253-208-028-513  
PLACE OF BIRTH RECEIVED

JUN 8 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Franklin BUREAU OF VITAL STATISTICS  
City of Idaho CERTIFICATE OF BIRTH  
No.                      St.                      Registration District No. 30 File No. 101442  
Hospital                      Primary Registration District No. 1051 Registered No. 1306  
FULL NAME OF CHILD Gertrude Kibbel

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin <u>                    </u> Triplet <u>                    </u> or other? <u>                    </u> } and { Number in order of birth <u>                    </u>	Legitimate? <u>Yes</u>	Date of birth <u>May 8</u> 192 <u>2</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FULL NAME <u>Mike Kibbel</u>	FATHER	FULL MAIDEN NAME <u>Lucie E. Eichen</u>	MOTHER
RESIDENCE <u>Gibbs</u>		RESIDENCE <u>Gibbs</u>	
COLOR <u>Or</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>Or</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Hungary</u>		BIRTHPLACE <u>Hungary</u>	
OCCUPATION <u>Laborem</u>		OCCUPATION <u>House wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Dead at 6 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. D. Drennon

Give names added from a supplemental report.

Address Coeur d'Alene, Id.

Filed 6/14 1922 D. D. Drennon

Registrar.

Registrar.

SEVERAL REASONS WHY A  
BE FILED FOR

OF BIRTH S

**BUREAU OF VITAL STATISTICS**  
The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

**BUREAU OF VITAL STATISTICS.**

Place of Birth { City Coeur D'Alene  
Street Corner of Lind and Lincoln  
County Boo Lanie

File Number 101442

Registration Dist. No. ....

Sex of Child Female Date of Birth May 8 1922

Father Mike Kelbel Mother Lucy Eachon  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Gertrude Kelbel  
Child's Name in Full

Mike Kelbel Lucy Kelbel  
Signature of Father or Mother

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

---

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

433-207-228-314  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Kootenai RECEIVED

City of Coeur d'Alene JUN 8 1922

No. 1510 3<sup>rd</sup> St. BUREAU OF VITAL STATISTICS

No. 30

File No. 101444

Hospital Red.

Primary Registration District No. 1051

Registered No. 7328

FULL NAME OF CHILD

Joyce Marie McLaughlin  
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>30</u>	Legitimate? <u>Yes</u>	Date of birth <u>May 7</u> 192 <u>2</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth None

FATHER  
FULL NAME Eliot Rife McLaughlin  
RESIDENCE Coeur d'Alene

MOTHER  
FULL MAIDEN NAME Helene Marie Laintzen  
RESIDENCE Coeur d'Alene

COLOR White AGE AT LAST BIRTHDAY 25 (Years)

COLOR White AGE AT LAST BIRTHDAY 21 (Years)

BIRTHPLACE Crookston Minn

BIRTHPLACE Bemidji Minn

OCCUPATION Craftsman

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

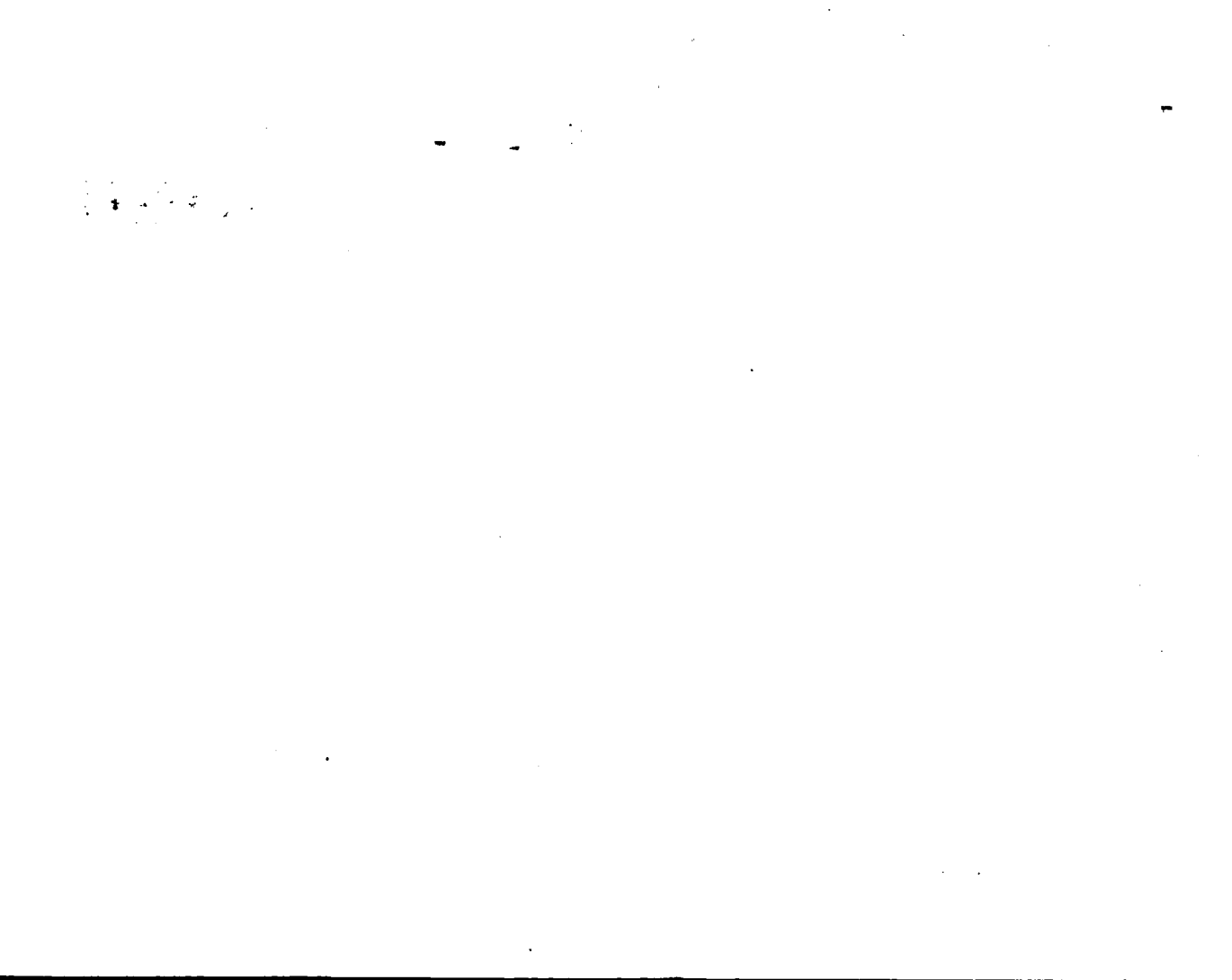
I hereby certify that I attended the birth of this child, who was Stillborn at 9<sup>30</sup> A. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. C. Shreve Dr.  
Physician or Midwife  
(Physician or Midwife)

Give names added from a supplemental report.  
....., 19.....  
Registrar.

Address Coeur d'Alene, Ida.  
Filed 6/14 1922 S. D. Drennon  
Registrar.



## PLACE OF DEATH

RECEIVED

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 38101

Registered No. 1867

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back ofCounty of *Kootenai* District No. *1*  
City of *Coeur d'Alene* Primary Registration District No. *1*  
*Hospital* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Joyce Marie McLaughlin*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED*Female* *White* *Single*  
(Write the word.)

6. DATE OF BIRTH

*May* *7* *1922*  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*E R McLaughlin*

11. BIRTHPLACE OF FATHER

(State or Country)

*Idaho*

12. MAIDEN NAME OF MOTHER

*Helena Lauritzen*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*E R McLaughlin*

(Address)

*Coeur d'Alene Idaho*

15.

Filed

*6/2*

19

*22**W D Brennan*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*May* *7* *1922*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Still born*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*May 7 1922*(Address) *Coeur d'Alene Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Forest Cemetery**May 8 1922*

UNDERTAKER

ADDRESS

*R B Mooney* *Coeur d'Alene*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

815-116-028-439  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Kootenai  
City of Coeur d'Alene  
No. 1  
Hospital 1  
Registration District No. 30  
Primary Registration District No. 151  
File No. 101452  
Registered No. 1315  
FULL NAME OF CHILD John Hansen  
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other <u>one</u> and (To be answered only in event of plural births)	Number in order of birth <u>one</u>	Legiti- mate? <u>yes</u>	Date of birth <u>May 16</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	---

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FULL NAME <u>Olas, Hansen</u>	FATHER	FULL MAIDEN NAME <u>Jimmie Erickson</u>	MOTHER
RESIDENCE <u>Coeur d'Alene Ida.</u>		RESIDENCE <u>Coeur d'Alene Ida.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Norway</u>		BIRTHPLACE <u>Norway</u>	
OCCUPATION <u>Lumber worker</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born at 6 P. M.  
on the date above stated. (Born alive or stillborn)

{When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

V. H. Kaedeen  
Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

6/5 1922  
D. D. Dring  
Registrar.

Registrar.

Secret

FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

38105 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Franklin Registration District No. 30  
City of Colonia Suburban St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

John Hanson

File No. ....

Registered No. 1072

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

5 16 1922  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

Olaf Hanson

## 11. BIRTHPLACE OF FATHER

(State or Country) Norway

## 12. MAIDEN NAME OF MOTHER

Jennie Kristerson

## 13. BIRTHPLACE OF MOTHER

(State or Country) Norway

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Olaf Hanson

(Address) .....

## 15.

Filed 9 19 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 16 1922  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 19 to 19that I last saw him alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Pneumonia (6 months)(Duration) Yrs. mos. ds.Contributory  
(Secondary)(Duration) Yrs. mos. ds.(Signed) M. H. Haedrick M. D.5/17 1922 (Address) Colonia, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Forest Cem. Colonia

## DATE OF BURIAL

5-17-1922

## 20. UNDERTAKER

C. Cassidy

## ADDRESS

Colonia

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

359-121-028-234  
PLACE OF BIRTH

RECEIVED  
JUN 8 1922  
BUREAU OF VITAL STATISTICS

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11—20m-7-26-19

S

County of Kootenai

City of Post Falls

Registration District No. 3

File No. **101460**

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 051

Registered No. 132

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Leisch

Sex of Child

male

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and

Number  
in order  
of birth

Legiti-  
mate?

yes

Date of  
Birth

Apr 21

(Month)

(Day)

1922  
(Year)

FATHER  
FULL NAME

Christ Leisch

RESIDENCE

Post Falls

COLOR

white

AGE AT LAST  
BIRTHDAY

42  
(Years)

BIRTHPLACE

Austria

OCCUPATION

Lumber yard Laborer

MOTHER  
FULL MAIDEN  
NAME

Anna Stumper

RESIDENCE

Post Falls

COLOR

white

AGE AT LAST  
BIRTHDAY

32  
(Years)

BIRTHPLACE

Austria

OCCUPATION

House-keeper

Number of child of this mother, including present birth 9

Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at \_\_\_\_\_ M.  
on the date above stated.

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

Given names added from a supplemental report.

(Signature)

J. L. McCauley

(Physician or midwife)

Post Falls

Address

Filed

1922

Registrar.

Registrar.

DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF CHILD STATISTICS  
CERTIFICATE OF BIRTH

County of Alameda  
City of Oakland  
Registration District No. 3

Primary Registration District No. 1  
Registered on 10/14/64

NAME OF CHILD

First Name Charles  
Middle Name Edward  
Last Name Wright  
Sex Male  
Date of Birth 10/14/64  
Time of Birth 11:30  
Place of Birth Alameda County, California

MOTHER

FULL NAME Charles Edward Wright

RESIDENCE 1014 14th St

COLOR White

AGE AT LAST BIRTHDAY 11

BIRTHPLACE Alameda County, California

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I, Dr. Charles E. Wright, a duly licensed physician or midwife, do hereby certify that I attended the birth of this child, who was born on 10/14/64 at 11:30 in Alameda County, California.

(Signature)

Dr. Charles E. Wright  
1014 14th St  
Oakland, California  
10/14/64

Dr. Charles E. Wright, M.D.  
1014 14th St  
Oakland, California  
10/14/64

Address

1014 14th St

RECEIVED OCT 20 1964

859-125-030-859

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-3-17

S

County of Laramie

MAY 2 1922

CERTIFICATE OF BIRTH

City of Salmon

BUREAU OF VITAL STATISTICS

Registration District No. 41File No. 101492No. 31Primary Registration District No. 2116

Registered No. ....

Hospital .....

FULL NAME OF CHILD Not named

Sex of Child <u>4</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth <u>Apr 23</u> Month (Day) (Year) <u>1922</u>
--------------------------	---	--------------------------------------	-----------------------------	--

FATHER  
FULL NAME Samuel Dean Hershberger  
RESIDENCE Salmon  
COLOR White AGE AT LAST BIRTHDAY 52 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Miner

MOTHER  
FULL MAIDEN NAME Fanny Hershberger  
RESIDENCE Salmon  
COLOR White AGE AT LAST BIRTHDAY 46 (Years)  
BIRTHPLACE Kansas  
OCCUPATION Housewife

Number of child of this mother, including present birth 9 Number of children of this mother now living, including present birth 5

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was sa. 11. 20 (Born alive or stillborn) at 9:30 P M. on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas F Hammer  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

..... 19.....

Address Salmon Idaho

.....

Filed 5/5 1922 Chas E. Billings

Registrar

Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

1

2

3

4



536-120-033-246

RECEIVED

JUN 6 1922

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

BUREAU OF VITAL  
STATISTICSSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 101530

County of MadisonCity of Rexburg

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 100

File No. \_\_\_\_\_

Hospital ResPrimary Registration District No. 2178Registered No. 125

FULL NAME OF CHILD \_\_\_\_\_

Sex of  
ChildMaleTwin  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti  
mate?yesDate of  
BirthJan 20 1922  
(Month) (Day) (Year)FULL  
NAMEK. Etanaga

FATHER

RESIDENCE

Rexburg Idaho

COLOR

Japneas

AGE AT LAST

BIRTHDAY

4 1/2  
(Years)

BIRTHPLACE

Japan

OCCUPATION

farmerFULL  
MAIDEN  
NAMEKiku Kurumamoto

MOTHER

RESIDENCE

Rexburg Idaho

COLOR

Japneas

AGE AT LAST

BIRTHDAY

29  
(Years)

BIRTHPLACE

Japan

OCCUPATION

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 8:20 a.m.  
on the date above stated. (Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Mary G. Watts  
Midwife

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Rexburg Idaho

Filed

7/30

19

22

Registrar

Registrar

2 104530

No. 10

District No. 10

Registered No. 10

Registration No. 10

Full Name of Child

MOTHER

FATHER

DATE

AGE AT BIRTH

SEX

DATE

DECEASED

PHYSICIAN'S SIGNATURE

(Signature)

Register

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

814-122-034-119  
PLACE OF BIRTH

RECEIVED

JUN 6 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Munido

City of Rupert

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Registration District No. 19

File No. 101581

Primary Registration District No. 2015

Registered No. 89

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth {	Legiti- mate? <u>Yes</u>	Date of birth (Month) <u>22</u> (Day) <u>22</u> (Year) <u>1922</u>
-----------------------------	---	---	--------------------------------	--

What bactericidal solution was used in eyes? ag no.

Number of child of this mother, including present birth... 4 Number of child of this mother now living, including present birth... 3

FATHER  
FULL NAME Frank Samman  
RESIDENCE Rupert  
COLOR White AGE AT LAST BIRTHDAY 29 (Years)  
BIRTHPLACE Utah  
OCCUPATION Rancher

MOTHER  
FULL MAIDEN NAME Gertha Gardine  
RESIDENCE Rupert  
COLOR White AGE AT LAST BIRTHDAY 30 (Years)  
BIRTHPLACE Utah  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn (Born alive or stillborn) 2 P M.  
on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. P. Evans  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
Registrar.

Address Rupert  
Filed May 28 1922 Registrar.

OFFICE OF STATE STATISTICS  
 DEPARTMENT OF HEALTH

Registration District No. \_\_\_\_\_  
 Primary Registration No. \_\_\_\_\_

State of New York

Name of child at birth _____		Sex _____	
Date of birth _____		Place of birth _____	
Name of mother _____		Name of father _____	
Address of mother at time of birth _____		Address of father at time of birth _____	
Color _____		Age at last birthday _____	
Birthplace _____		Occupation _____	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
 (Name of child) \_\_\_\_\_

(Signature)

(Date of birth)

Address

File

754-127-038-994

Form V. S. No. 11--50m-7-20-23

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of PayetteCity of Payette

No. \_\_\_\_\_

St. \_\_\_\_\_

Registration District No. 4

File No. \_\_\_\_\_

101642

Hospital \_\_\_\_\_

Primary Registration District No. 1008Registered No. 42FULL NAME OF CHILD UnnamedStillbornSex of Child MaleTwin  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legitimate?

Yes

Date of Birth

May 271922

(Month) (Day) (Year)

FULL NAME

FATHER  
Henry Peutz

RESIDENCE

Payette, Ida.

COLOR

WhiteAGE AT LAST  
BIRTHDAY50

(Years)

BIRTHPLACE

Germany

OCCUPATION

RetiredFULL  
MAIDEN  
NAME

MOTHER

Amanda Zimmerman

RESIDENCE

Payette, Ida

COLOR

WhiteAGE AT LAST  
BIRTHDAY33

(Years)

BIRTHPLACE

Germany

OCCUPATION

HousewifeNumber of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:00 A. M.  
on the date above stated. (Born alive or stillborn)

(Signature)

O. H. AveryPhysician

(Physician or midwife)

Address

Payette Idaho

Filed

May 29 1922 J. C. Woodward

Registrar.

Registrar.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

19

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

IN THE MATTER OF THE ESTATE OF JAMES H. HARRIS, DECEASED

old

## References

ALBERT EINSTEIN

**0-20E**  
**1-20E**

of place  
in order  
to meet

(attest) \_\_\_\_\_ 10/1/98

**LU  
CH  
MA**

**● 2013 年 12 月 29 日**

**COLON**

TRAJ TA CH  
YACHIN

## EDUCATION

**NOTARIZED**

STATE OF ATTENDING

(continued)

in addition to the above, the following information was obtained from the above mentioned sources:

FROM: [REDACTED] TO: [REDACTED]

**www.bba**

b6  
b7C  
b7D

# DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, ..... 192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City Payette .....  
 { Street .....  
 { County Payette .....  
 Sex of Child Male .....  
 Date of Birth May 27 ..... 192...  
 Father Henry Pentz ..... Full Name  
 Mother Amanda Anna Zime ..... Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

We did not name the Baby, because it was still  
 Child's Name in Full

Mrs. Henry Pentz  
 Signature of Father or Mother

OVER

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are com-  
pelled to furnish certified copies of certificates of birth, it is im-  
portant that the certificates be filed with the BUREAU OF VITAL STATIS-  
TICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Payette*  
City of *Payette*

Registration District No. *4*Primary Registration District No. *1008*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*white*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Single*

(Write the word.)

## 6. DATE OF BIRTH

*May 27 1922*  
(Month) (Day) (Year)

## 7. AGE

Yrs. — Mos. — ds.

IF LESS than 1 day  
how many — hrs.  
or — min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

*Payette Idaho*

## 10. NAME OF FATHER

*Henry Peuty*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Germany*

## 12. MAIDEN NAME OF MOTHER

*Amanda Zimmerman*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Germany*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Henry Peuty*  
*Payette Idaho*

## 15.

Filed *May 29 1922*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*May 27 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19. to *May 27 1922*

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Still birth*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*A. H. Avery*

M. D.

*5/27/1922* (Address) *Payette Idaho*

\*State the Disease Causing Death; or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Payette Idaho May 27 1922*

## 20. UNDERTAKER

## ADDRESS

*Glenn C Landon Payette Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

711-224-039-455

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 101658

County of Power

City of \_\_\_\_\_

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2072 Registered No. 392

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Dorothy Louise Parr

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth <u>2</u>	Legitimate? <u>Yes</u>	Date of Birth <u>Mar 24 1922</u> (Month) (Day) (Year)
----------------------------	------------------------------	-----------	-----------------------------------	------------------------	--

FATHER  
FULL NAME Wm Leslie Parr  
RESIDENCE Hegler

MOTHER  
FULL MAIDEN NAME Belle Ramsey  
RESIDENCE Hegler

COLOR White AGE AT LAST BIRTHDAY 25  
(Years)

COLOR White AGE AT LAST BIRTHDAY 26  
(Years)

BIRTHPLACE Minnesota  
OCCUPATION farmer

BIRTHPLACE Minnesota  
OCCUPATION Housewife

Number of child of this mother, including present birth. 2 Number of children of this mother now living, including present birth. 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was still born, at 3 a.m.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

(Physician or midwife)

Given names added from a supplemental report.

Address \_\_\_\_\_

Filed \_\_\_\_\_

Registrar \_\_\_\_\_

Registrar \_\_\_\_\_

Form 100-1 (Rev. 1-1-60) U.S. DEPARTMENT OF JUSTICE

City of \_\_\_\_\_  
No. \_\_\_\_\_

Home \_\_\_\_\_  
Full name \_\_\_\_\_

State of \_\_\_\_\_  
County of \_\_\_\_\_  
Municipality of \_\_\_\_\_  
Municipality only in case of city (check)

Full name \_\_\_\_\_  
Maiden name \_\_\_\_\_  
Residence \_\_\_\_\_

Color \_\_\_\_\_  
Age at last \_\_\_\_\_  
Birth date \_\_\_\_\_

Marriage \_\_\_\_\_  
Occupation \_\_\_\_\_

**CERTIFICATE OF ATTENDING PHYSICIAN**

I, \_\_\_\_\_, a \_\_\_\_\_ of \_\_\_\_\_, do hereby certify that \_\_\_\_\_

(Signature)

(Date or initials)

I have examined \_\_\_\_\_ and \_\_\_\_\_  
and have found \_\_\_\_\_

JUL 12 1922

**BUREAU OF VITAL  
STATISTICS**

## STATE OF IDAHO

## DEPARTMENT OF PUBLIC WELFARE

**Boise, Idaho.**

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City Regina File Number 101658  
 { Street \_\_\_\_\_  
 { County Cassia Registration Dist. No. \_\_\_\_\_  
 Sex of Child Female Date of Birth Mar. 24 1922  
 Father William Leslie Full Name Mother Belle Denny Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Dorothy Louise Parr  
Child's Name in Full

Mrs. Wm. L. Davis  
Signature of Father or Mother

CVT-1

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED  
CERTIFICATE OF DEATH38630 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of Power

Priority Registration District No. 2072

City of

St.)

File No. 44

Registered No. 160

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Not named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Fem

white

Singles  
(Write the word.)

6. DATE OF BIRTH

1  
(Month) (Day) (Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day  
how many hrs. or  
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W. Leslie Part.

11. BIRTHPLACE OF FATHER

(State or Country)

Minn.

12. MAIDEN NAME OF MOTHER

Belle Denney

13. BIRTHPLACE OF MOTHER

(State or Country)

Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

V. G. Logan

(Address)

Candian fall.

15.

Filed

6 - 21

1922

R. J. Noth

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

24

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still birth

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

V. G. Logan

M. D.

6/12 1922 (Address) Candian fall, Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Higlar Ida

Apr 24 1922

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

249-218-040-154  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S -

101664

County of Shoshone

City of Wallace

No. 104 St. Providence

Hospital Providence

RECEIVED MAY 28 1922

BUREAU OF VITAL STATISTICS

Registration District No. 70

CERTIFICATE OF BIRTH

File No. 8

Registered No. 8

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin <u>Yes</u> and <u>Yes</u> or other? (To be answered only in event of plural births)	Number in order of birth <u>8</u>	Legitimate? <u>Yes</u>	Date of birth <u>Jan 18</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	--	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 6

FATHER Arthur J. Smith  
RESIDENCE Wallace, Idaho  
COLOR W AGE AT LAST BIRTHDAY 46 (Years)  
BIRTHPLACE Tennessee  
OCCUPATION Laborer

MOTHER Thelma Anderson  
RESIDENCE Wallace, Idaho  
COLOR W AGE AT LAST BIRTHDAY 38 (Years)  
BIRTHPLACE Mississippi  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 6:10 P. M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. M. W. Ward  
Physician or midwife

Give names added from a supplemental report.  
....., 19.....  
.....  
Registrar.

Address Wallace, Idaho  
Filed Jan 30 1922 F. L. Finney  
Registrar.

RECORDED  
INDEXED  
JAN 13 1924  
U.S. DEPT. OF JUSTICE  
DIVISION OF INVESTIGATION

**CERTIFICATE OF BIRTH**

County of \_\_\_\_\_  
City of \_\_\_\_\_  
No. \_\_\_\_\_  
Registration District No. \_\_\_\_\_  
Full Name of Child \_\_\_\_\_

Sex of Child \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Place of Birth \_\_\_\_\_

Number of child of this mother now living \_\_\_\_\_  
Number of child of this mother now dead \_\_\_\_\_

Full Name of Mother \_\_\_\_\_  
Maiden Name \_\_\_\_\_  
Residence \_\_\_\_\_

Color \_\_\_\_\_  
Age at Birth \_\_\_\_\_  
Birthplace \_\_\_\_\_

Occupation \_\_\_\_\_  
Birthplace \_\_\_\_\_  
Occupation \_\_\_\_\_

**CERTIFICATE OF ATTENDING PHYSICIAN**  
I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

Signature of Physician \_\_\_\_\_  
Date \_\_\_\_\_  
Place \_\_\_\_\_

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5 20M.1-16-12

# CERTIFICATE OF DEATH

38214

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

70

County of

Shoshone

Registration District No.

70

City of

Wallace

BUREAU OF VITAL STATISTICS

Waller's Providence Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant of A. J. Smith

File No.

Registered No.

10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white

single (Write the word.)

6. DATE OF BIRTH

July 18 1922  
(Month) (Day) (Year)

7. AGE

still born

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

A. J. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Mary O. Andrews

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Smith

(Address)

110 Elm St.

15.

Filed

Jan 20 1923

1923

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 18 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on

191

and that death occurred on the date stated above, at

6:02 PM

The CAUSE OF DEATH\* was as follows:

still born

(Duration) yrs. mos. ds.

Contributory (Secondary)

Premature birth

(Duration) yrs. mos. ds.

(Signed)

Dr. W. W. W. M.D.

1/19 1922 (Address) Wallace, Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida

Jan 20 1922

20. UNDERTAKER

ADDRESS

W. W. W.

Wallace

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

261-224-040-859

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of ShoshoneRECEIVED  
MAY 28 1922  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

City of BurkeRegistration District No. 70File No. S 101674

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 104 Registered No. 17

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Miss Soards (Still Born)

Sex of Child

7Twin  
Triplet  
or other?One andNumber  
in order  
of birthLegiti  
mate?7

Date of Birth

Feb 241922

(Month)

(Day)

(Year)

FULL NAME

FATHER

Rogert J. Soards

FULL MAIDEN NAME

MOTHER

Cassie Harrington

RESIDENCE

Burke

RESIDENCE

Burke

COLOR

W

AGE AT LAST BIRTHDAY

38

(Years)

COLOR

W

AGE AT LAST BIRTHDAY

34

(Years)

BIRTHPLACE

Ido

BIRTHPLACE

Ido

OCCUPATION

Miner

OCCUPATION

House wifeNumber of child of this mother, including present birth 4Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born, at 11 P. M.  
on the date above stated. (Born alive or stillborn)

(Signature)

D. A. A. W. D. D. D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Burke 704

FILED

19

Registrar

Registrar

THE UNIVERSITY OF CHICAGO

[illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No.

70

County of

Primary Registration District No.

File No.

City of

(No.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still born child R. J. Soards

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Feb 25 1922  
(Month) (Day) (Year)

7. AGE

still born  
yrs. mos. ds.IF LESS than 1 day  
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Royester J Soards

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Cassie L Soards

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Royester Soards  
Burke Ida

15.

Filed

Feb 4 1922 J. J. Soards

Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 25 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Chas. A. Drea M. D.

19

(Address)

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace Ida Feb 4 1922

20. UNDERTAKER

ADDRESS

R. J. Soards Wallace

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid-Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

962-122-040-385  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Shoshone **RECEIVED**  
City of Mullan **MAY 23 1922** **CERTIFICATE OF BIRTH**  
No. \_\_\_\_\_ St. \_\_\_\_\_ **BUREAU OF VITAL** **70** File No. **101692**  
Hospital \_\_\_\_\_ Primary Registration District No. 1011 Registered No. 29  
FULL NAME OF CHILD Hullborn

(Certificate of no value without full name of child.)

Sex of Child <u>m</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>7/22</u> 192 <u>2</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bacteriocidal solution was used in eyes? No

Number of child of this mother, including present birth... 3 Number of child of this mother now living, including present birth... 2

FULL NAME <u>Wm Roy Roberts</u>	FATHER	FULL MAIDEN NAME <u>Lula Lynch</u>	MOTHER
RESIDENCE <u>Mullan</u>		RESIDENCE <u>Mullan</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Mich</u>		BIRTHPLACE <u>Ida</u>	
OCCUPATION <u>Miner</u>		OCCUPATION <u>Stn</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

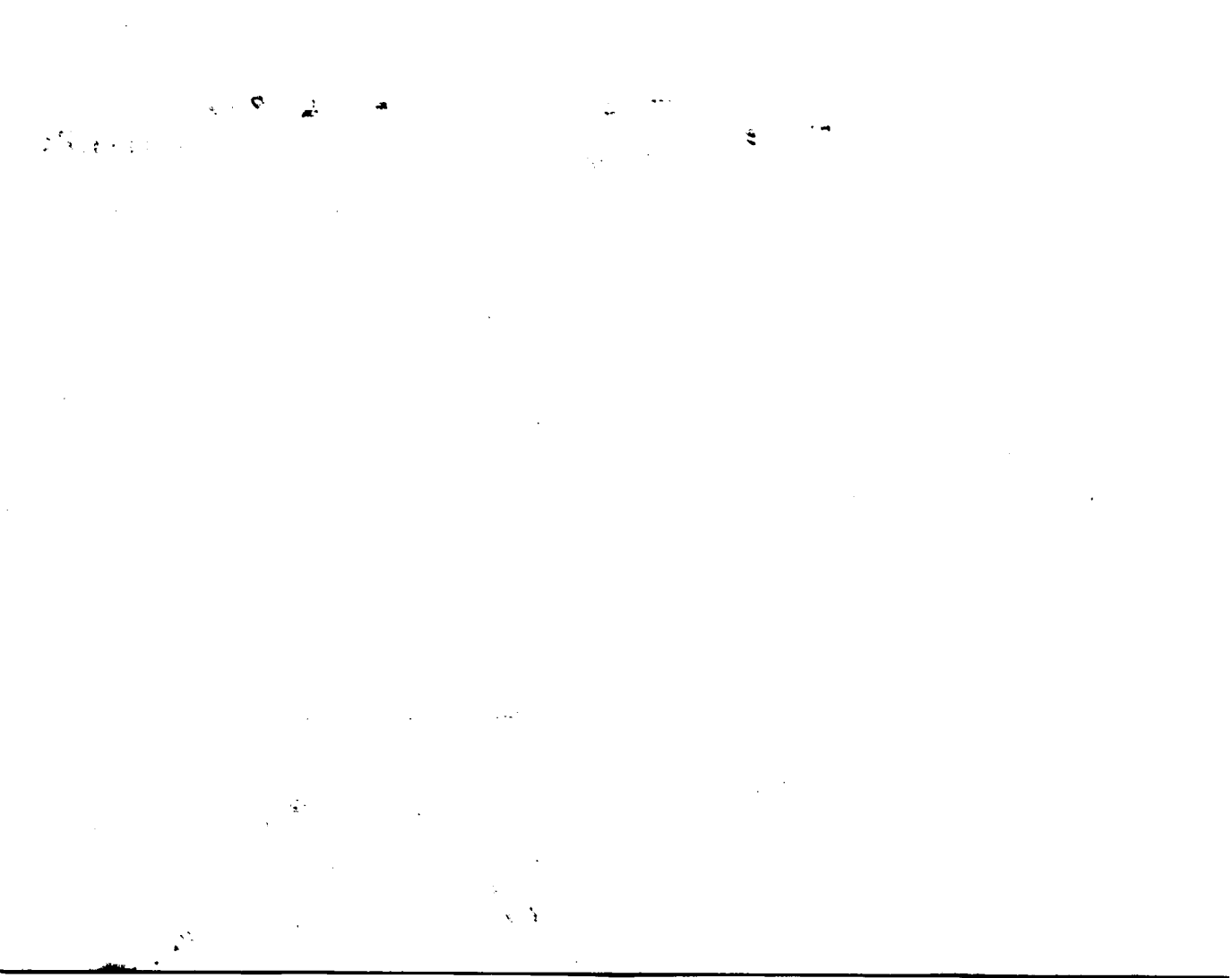
I hereby certify that I attended the birth of this child, who was born alive at 6:30 P. M.  
on the date above stated. Hullborn (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) James R. Bear  
(Physician or midwife)

Give names added from a supplemental report.

Address Wallace Idaho  
up 30 1922  
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1.16.18

# CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH *Shoshone* Registration District No. *70*  
County of *Shoshone* Primary Registration District No. *104*  
City of *Mullan* (No. *Mullan* St.)

File No. *18*  
Registered No. *18*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Maates Roberts*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*  
(Write the word.)

6. DATE OF BIRTH *9* (Month) *1* (Day) *1922* (Year)

7. AGE *Stillborn* IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work *none*  
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) *Mullan Idaho*

10. NAME OF FATHER *H. R. Roberts*

11. BIRTHPLACE OF FATHER (State or Country) *Michigan*

12. MAIDEN NAME OF MOTHER *Lulu Lynch*

13. BIRTHPLACE OF MOTHER (State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *H. R. Roberts*  
(Address) *Mullan Ida*

15. Filed *Feb 24* 1922 *F. L. Deussen* Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb 22* 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb 22* 1922, to *Feb 22* 1922,

that I last saw h. alive on *1922*

and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH\* was as follows:

*Stillborn*  
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.  
(Signed) *James R. Bean* M. D.  
*2/23 1922* (Address) *Wallace*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence *none*

19. PLACE OF BURIAL OR REMOVAL *Mullan Ida* DATE OF BURIAL *Feb 24 1922*

20. UNDERTAKER *Hardy & Co* ADDRESS *Wallace Ida*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

595-117-042-795

Form V. S. No. 11-C-25a-7-21-19

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

S

County of Twin Falls

MAY 23 1922

CERTIFICATE OF BIRTH

City of Twin FallsBUREAU OF VITAL  
STATISTICS 37File No. 101764

No. \_\_\_\_\_ St. \_\_\_\_\_

1085

Hospital Co Hosp

Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth <u>4</u>	Legiti mate? <u>yes</u>	Date of Birth <u>April 17</u> 19 <u>22</u> (Month) (Day) (Year)
--------------------------	---	-----	--	-------------------------------	--

FULL NAME <u>Martin Neuring</u>	FATHER
RESIDENCE <u>Missouri Buhl Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>4 3</u> (Years)
BIRTHPLACE <u>Missouri</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Emma Dieker</u>	MOTHER
RESIDENCE <u>Buhl Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Nebraska</u>	
OCCUPATION <u>Farmer</u>	

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 10:30 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed May 919 22

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

Eye treatment to  
2022-10-22

FULL NAME [Handwritten: John Doe]		DATE OF BIRTH [Handwritten: 01/01/1900]		PLACE OF BIRTH [Handwritten: New York]	
RESIDENCE [Handwritten: 123 Main St, New York]		OCCUPATION [Handwritten: Teacher]		EDUCATION [Handwritten: High School]	
MARRIAGE [Handwritten: Married]		CHILDREN [Handwritten: 2]		RELIGION [Handwritten: Catholic]	
SIGNATURE [Handwritten: John Doe]		DATE [Handwritten: 01/01/1900]		PLACE [Handwritten: New York]	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED  
MAY 23 1922

CERTIFICATE OF DEATH

38269

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*

District No. *37*

City of *Stanley*

Registration District No. *1085*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Nieweg*

File No. ....

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Male*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

*Single*  
(Write the word.)

6. DATE OF BIRTH

*Apr*  
Month

*17*  
(Day)

*1922*  
(Year)

7. AGE

Yrs.

Mos.

*0* ds.

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Twin Falls, Ida*

10. NAME OF FATHER

*Martin Nieweg*

11. BIRTHPLACE OF FATHER

(State or Country)

*Mo*

12. MAIDEN NAME OF MOTHER

*Emma Giesler*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Neb.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Martin Nieweg*

(Address)

*Buhl, Ida*

15.

Filed

*May 1*

*1922*

*John F. Hough*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Apr 17*  
Month

*17*  
(Day)

*1922*  
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*never lived*  
that I last saw him alive on *19*

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

*Still birth*  
*Rapid version, delivery*  
*with water in eclampsia*

(Duration)

Yrs.

mos.

ds.

Contributory  
(Secondary)

*Pre-natal toxemia*

(Duration)

Yrs.

mos.

ds.

(Signed)

*A. F. Chubb*

M. D.

*4/17/22*

(Address)

*Buhl, Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL

*Clover, Ida*

DATE OF BURIAL

*11/18 1922*

20. UNDERTAKER

*J. P. Grossman*

ADDRESS

*Twin Falls, Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

766-223-042-613  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

101766

County of Twin Falls

MAY 28 1922

City of Twin Falls

No. 442-2nd E St.

Registration District No. 37

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 1085

Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Goodrich

(Certificate of no value without full name of child.)

Sex of  
Child

Female

Twin  
Triplet  
or other?

{ and }

Number  
in order  
of birth

Legiti-  
mate?

yes

Date of  
birth

Apr 23

1922  
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? \_\_\_\_\_

none stillborn

Number of child of this mother, including present birth \_\_\_\_\_

Number of child of this mother now living, including present birth \_\_\_\_\_

FULL  
NAME

FATHER

Lloyd Goodrich

RESIDENCE

Twin Falls

COLOR

white

AGE AT LAST  
BIRTHDAY

24  
(Years)

BIRTHPLACE

Iowa

OCCUPATION

Auto driver

FULL  
MAIDEN  
NAME

MOTHER

Gladys Walters

RESIDENCE

Twin Falls

COLOR

white

AGE AT LAST  
BIRTHDAY

20  
(Years)

BIRTHPLACE

Oklahoma

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

stillborn

(Born alive or stillborn)

M.

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

How Shonchell  
Physician

(Physician or midwife)

Give names added from a supplemental report.

Address

Twin Falls, Idaho

Filed

May 9

1922

Registrar.

Registrar.

RECEIVED THE DIRECTOR OF THE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
JAN 11 1964  
FROM THE DIRECTOR OF THE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
TO THE DIRECTOR OF THE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
SUBJECT: [REDACTED]

DECLASSIFIED

REPORT TO STATE  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

\_\_\_\_\_

\_\_\_\_\_

100-443887-100

\_\_\_\_\_

RENTON

\_\_\_\_\_

SECRET



SS 1951

FORM 7, S. No. 57—25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

Twin Falls

Registration District No. 37

County of

Primary Registration District No. 10.85

City of

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Goodrich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDSingle  
(Write the word.)

6. DATE OF BIRTH

April - 23 - 1922  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Twin Falls, Ida

10. NAME OF FATHER

Lloyd Goodrich

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Gladys Walters

13. BIRTHPLACE OF MOTHER

(State or Country)

Okla.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

May-7- 1922

John J. Long  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 23 - 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1922, to April 22, 1922  
that I last saw him alive on 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. W. Hanchett M. D.

1922

(Address) Twin Falls, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls, Ida

DATE OF BURIAL

Apr. 24, 1922

20. UNDERTAKER

R. J. Brown

ADDRESS

Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

652-227-042-893

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of Twin Falls

MAY 23 1922

CERTIFICATE OF BIRTH

S

City of

BUREAU OF VITAL

STATISTICS

District No.

37

File No.

101770

No.

St.

Hospital

County

Primary Registration District No. 1085

Registered No.

FULL NAME OF CHILD

Baby Westney

Sex of  
Child

female

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)and  
Number  
in order  
of birth  
(To be answered only in event of plural births)Legiti  
mate?

yes

Date of  
BirthMar 27  
(Month) (Day)1922  
(Year)FULL  
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY42  
(Years)

BIRTHPLACE

OCCUPATION

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY37  
(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth. 6 Number of children of this mother now living, including present birth. 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.still born.  
(Born alive or stillborn)

at 8:10 P.M.

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

C. A. Thomas  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Twin Falls, Ida

Filed

May 1- 1922

1922

John F. McLaughlin  
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

No. \_\_\_\_\_  
 Hospital \_\_\_\_\_  
 Primary Physician \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Race \_\_\_\_\_  
 Religion \_\_\_\_\_  
 Marital Status \_\_\_\_\_  
 Education \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Residence \_\_\_\_\_  
 Date of Admission \_\_\_\_\_  
 Date of Discharge \_\_\_\_\_  
 Date of Death \_\_\_\_\_  
 Cause of Death \_\_\_\_\_  
 Number of Children of this Woman \_\_\_\_\_  
 Name of Attending Physician \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Date \_\_\_\_\_

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
 DATE 11-11-2011 BY 60322 UCBAW/DK/STP

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

474-111-001-154  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Ada JUL 6 1922  
City of Boise ~~BUREAU OF VITAL STATISTICS~~ CERTIFICATE OF BIRTH  
No. \_\_\_\_\_ St. Registration District No. 2 File No. 101793  
Hospital St. Alphonsus Primary Registration District No. 1004 Registered No. 253  
FULL NAME OF CHILD \_\_\_\_\_ Updegraff (Stillborn)  
(Certificate has no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth... <u>June 11</u> ... 1922. (Month) (Day) (Year)
-----------------------	---	-----	--------------------------------	-----------------------------	--

What bacteriocidal solution was used in eyes? None - stillborn

Number of child of this mother, including present birth..... Number of child of this mother now living, including present birth.....

FULL NAME <u>FATHER</u> <u>D. D. Updegraff</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Eva Anderson</u>
RESIDENCE <u>Boise, Ida.</u>	RESIDENCE <u>Boise, Idaho</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Mo.</u>	BIRTHPLACE <u>Minn.</u>
OCCUPATION <u>Salesman</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was..... June 11, at..... 10 P. M.  
on the date above stated. (~~From stillborn~~)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Joe R. Numbers

(Physician or midwife)

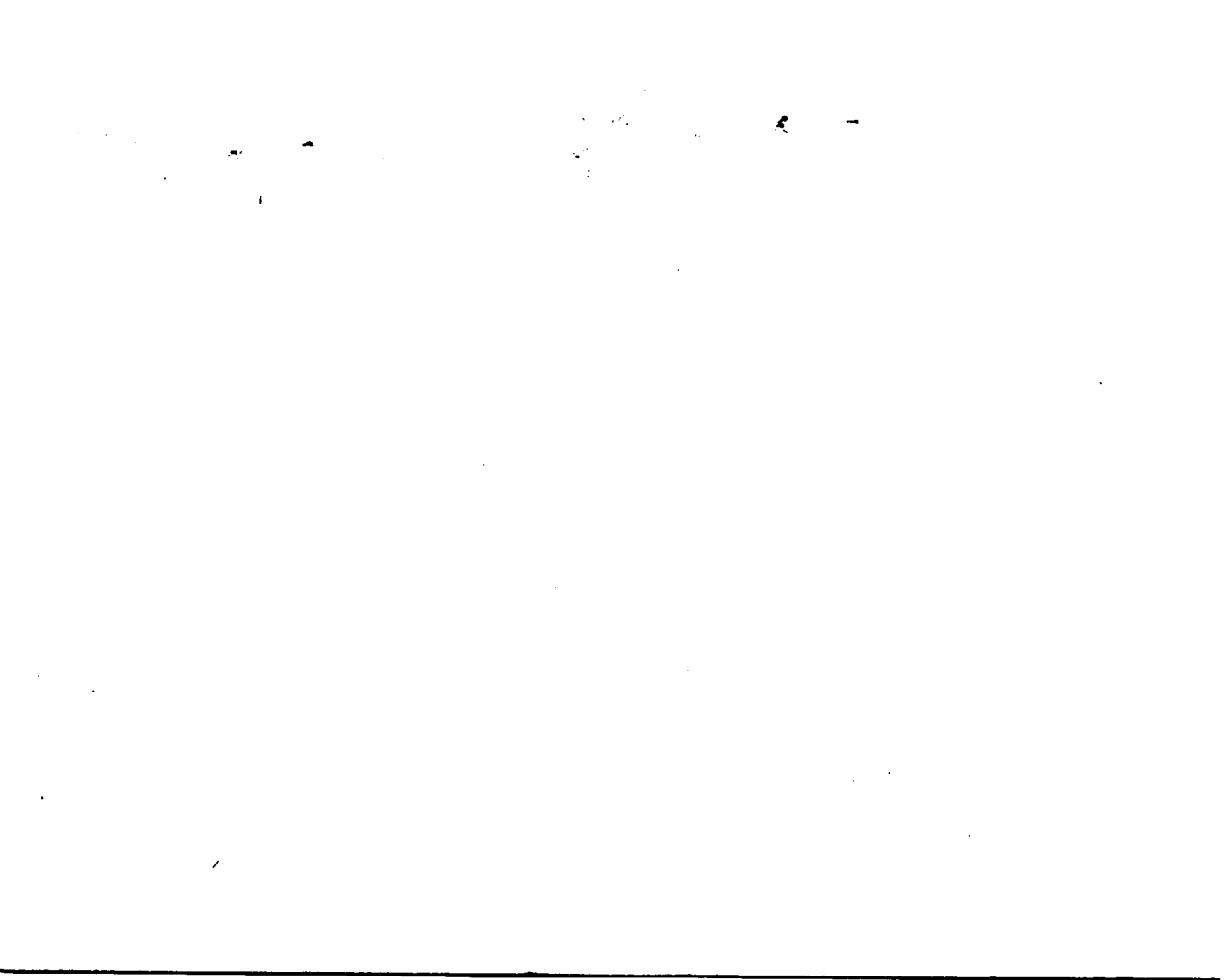
Give names added from a supplemental report.

Address Boise, Idaho

Filed 6-28 1922

Registrar. R. H. Pratt

Registrar.





MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEMBERS,  
CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **38292**  
Registered No. **139**

1. PLACE OF DEATH **REC**  
County of **Ada** JUL 0  
City of **Boise** BUREAU  
If death occurs away from usual residence, give facts called for under special information.

Registration District No. **2**  
Primary Registration District No. **1094**  
(No. **St Alphonsus Hospital**)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

**Infant Updegraff**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single** (word.)

6. DATE OF BIRTH **June 12 1922**  
(Month) (Day) (Year)

7. AGE **Yrs. Mos. ds.** IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work **None**  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **Idaho**

10. NAME OF FATHER **David D. Updegraff**

11. BIRTHPLACE OF FATHER (State or Country) **Missouri**

12. MAIDEN NAME OF MOTHER **Eva Anderson**

13. BIRTHPLACE OF MOTHER (State or Country) **Minnesota**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **David D. Updegraff**  
(Address) **Boise, Ida.**

15. Filed **6-12 1922** **A. H. Ratt**  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **June 18 1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased **from June 18th 1922 to June 12 1922** that I last saw him **10 P.M.** and that death occurred on the date stated above, at **10 P.M.** The CAUSE OF DEATH\* was as follows:  
**Stillborn**

(Duration) **Yrs. mos. ds.**  
Contributory (Secondary)  
(Duration) **Yrs. mos. ds.**  
(Signed) **Joe R. Hume** M. D.  
(Address) **Boise, Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death **Yrs. mos. days** In the State **Yrs. mos. days**  
Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Morris Hill Cemetery** DATE OF BURIAL **June 13 1922**  
20. UNDERTAKER **Summers & White** ADDRESS **Boise, Ida.**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

763-111-001-964  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Ada RECEIVED  
City of Boise JUL 6 1927  
No. St. Stephens St. St. Stephens Registration District No. 2 File No. 101795  
Hospital St. Stephens Primary Registration District No. 1004 Registered No. 255  
FULL NAME OF CHILD Goetting (still born)  
(Certificate of no value without full name of child.)

Sex of Child <u>m</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth... <u>June 11</u> ..... 192 <u>7</u> (Month) (Day) (Year)
-----------------------	---	-----	--------------------------------	-----------------------------	---

What bacteriocidal solution was used in eyes?..... None - Stillborn

Number of child of this mother, including present birth... 2..... Number of child of this mother now living, including present birth... 1.....

FATHER		MOTHER	
FULL NAME	<u>Chas. A. Goetting</u>	FULL MAIDEN NAME	<u>Nebel Roultan</u>
RESIDENCE	<u>Eagle Idaho</u>	RESIDENCE	<u>Eagle</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>33</u> (Years)	AGE AT LAST BIRTHDAY	<u>33</u> (Years)
BIRTHPLACE	<u>So. Dakota</u>	BIRTHPLACE	<u>So. Dakota</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was..... June 11..... at..... 2..... P. M.  
on the date above stated. (Stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Joe R. Ruchman, Jr.

(Physician or midwife)

Give names added from a supplemental report.

Address

Boise, Idaho

Filed

6-28 1927

H. L. Galt

Registrar.

Registrar.

100-100000

City of

County of

Registration Number

County Registration Number

County Registration Number

County Registration Number

REFERENCE

COLOR

REMARKS

REMARKS

REMARKS

REMARKS

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REMARKS

REMARKS

REMARKS

1. PLACE OF DEATH		COUNTY OF		CITY OF		STATE		REGISTRATION DISTRICT NO.		COUNTY OF		CITY OF		STATE		REGISTRATION DISTRICT NO.		FILE NO.		REGISTERED NO.	
Adia		Ada		Boise		Idaho		1006		Ada		Boise		Idaho		1004		38285		134	
<p>If death occurs away from usual residence, give facts called for under special information.</p> <p>2. FULL NAME <i>Leroy Robert Goettling</i></p>																					
<p>PERSONAL AND STATISTICAL PARTICULARS</p> <p>3. SEX <i>M.</i> 4. COLOR OR RACE <i>W.</i> 5. SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Single</i> (Write the word.)</p> <p>6. DATE OF BIRTH <i>June 11 - 1922</i> (Month) (Day) (Year)</p> <p>7. AGE <i>Still Born</i> IF LESS than 1 day how many hrs. or min.?</p> <p>8. OCCUPATION (a) Trade, profession or particular kind of work <i>None</i>. (b) General nature of industry, business or establishment in which employed (or employer)</p> <p>9. BIRTHPLACE (State or Country) <i>Boise Idaho</i></p> <p>10. NAME OF FATHER <i>Chas. A. Goettling</i></p> <p>11. BIRTHPLACE OF FATHER (State or Country) <i>South Dakota</i></p> <p>12. MAIDEN NAME OF MOTHER <i>Mable Rantson</i></p> <p>13. BIRTHPLACE OF MOTHER (State or Country) <i>South Dakota</i></p> <p>14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>W. McBratney</i> (Address) <i>Boise Idaho</i></p> <p>15. Filed <i>6-12</i> 19<i>22</i> <i>R. L. Pratt</i> Local Registrar</p>																					
<p>MEDICAL CERTIFICATE OF DEATH</p> <p>16. DATE OF DEATH <i>June 11 - 1922</i> (Month) (Day) (Year)</p> <p>17. I HEREBY CERTIFY, That I attended deceased from <i>June 11</i> 19<i>22</i>, to <i>June 11</i> 19<i>22</i> that I last saw him alive on <i>June 11</i> 19<i>22</i> and that death occurred on the date stated above, at <i>Boise</i> M.</p> <p>The CAUSE OF DEATH* was as follows: <i>Stillborn Had been dead 7 or 8 days before birth</i></p> <p>(Duration) Yrs. mos. ds.</p> <p>Contributory (Secondary)</p> <p>(Duration) yrs. mos. ds.</p> <p>(Signed) <i>Jos. R. Rummery</i> M. D. 19<i>22</i> (Address) <i>Boise, Idaho</i></p> <p>*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.</p> <p>18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)</p> <p>At place of death yrs. mos. days. In the State yrs. mos. days</p> <p>Where was disease contracted if not at place of death?</p> <p>Former or usual residence</p> <p>19. PLACE OF BURIAL OR REMOVAL <i>Morris Hill Cemetery</i> DATE OF BURIAL <i>6/12/22</i></p> <p>20. UNDERTAKER <i>W. McBratney</i> ADDRESS <i>Boise, Idaho</i></p>																					

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

229-115-001-884  
PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-25m-6-15-18

S

County of Ada  
City of Boise

Registration District No. 2

File No. 101799

No. 1916 7 15 St.

Primary Registration District No. 1004

Registered No. 257

Hospital

Full Name of Child

SEX OF CHILD <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimacy? <u>Yes</u>	DATE OF BIRTH <u>6/15/22</u> (Month) (Day) (Year)
FULL NAME <u>Harry @ Skurrier</u>	FATHER		FULL MAIDEN NAME <u>Mellie Young</u>	MOTHER
RESIDENCE <u>1916 7 15</u>			RESIDENCE <u>Ind</u>	
COLOR <u>Bl</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)		COLOR <u>Bl</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Iowa</u>			BIRTHPLACE <u>Ind</u>	
OCCUPATION <u>Auto Salesman</u>			OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth..... Number of children of this mother now living, including present birth.....

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report

(Signature)

(Born alive or stillborn)

at 11 30 A.M.

Address

Filed 6-28-1922

Registrar

Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATISTICS

BR 2

10-17-51



PLACE HERE

Country

10-17-51

10-17-51

10-17-51

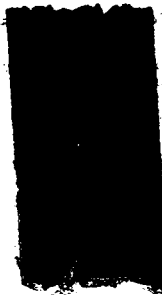
10-17-51

10-17-51

10-17-51

10-17-51

10-17-51





# CERTIFICATE OF DEATH

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. **38299**  
 Registered No. **176**

1. PLACE OF DEATH  
 Registration District No. **2**  
 County of **Idaho**  
 Primary Registration District No. **1004**  
 City of **Boise** (Not in 916, No. 15, St.)  
 If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

**Infant Skinner**

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**

## 6. DATE OF BIRTH

**June 15** 19**22**  
 (Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
 how many..... hrs.  
 or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer)

**None**

## 9. BIRTHPLACE

(State or Country)

**Idaho**

## 10. NAME OF FATHER

**Harry C. Skinner**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Idaho**

## 12. MAIDEN NAME OF MOTHER

**Hellie G. Young**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Idaho**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**Harry C. Skinner**

(Address)

## 15.

Filled

**June 16 1922**

**R. B. Pratt**  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

**1891**

## 16. DATE OF DEATH

**June 15** 19**22**  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

**6/15** 19**22** to **6/15** 19**22**

that I last saw her alive on **6/15** 19**22**

and that death occurred on the date stated above, at **11 A.M.**

The CAUSE OF DEATH\* was as follows:

**Still-born**

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **Frank A. Smith** M. D.

**6/15** 19**22** (Address) **Boise, Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

**Greenleaf, Idaho**

## DATE OF BURIAL

**June 16 1922**

## 20. UNDERTAKER

**Summers & Co.**

## ADDRESS

**Boise, Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

812-123-063-892

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—25m-9-8-15

S

County of Bainbridge (RECEIVED)  
City of Tyhee JUN 22 1922

## CERTIFICATE OF BIRTH

101847

No. 2000000 St.Registration District No. 2161File No. 4387

Hospital \_\_\_\_\_

Primary Registration District No. 2161Registered No. 4387

## FULL NAME OF CHILD

Asao HashimotoSex of Child male Twin Triplet or other? \_\_\_\_\_ { and } Number in order of birth \_\_\_\_\_ Legitimate? yes Date of Birth May 23 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)FATHER  
FULL NAME Asao Hashimoto  
RESIDENCE Tyhee Ida.  
COLOR white AGE AT LAST BIRTHDAY 39 (Years)  
BIRTHPLACE Japan  
OCCUPATION FarmerMOTHER  
FULL MAIDEN NAME Mikio Hisatome  
RESIDENCE Tyhee Ida.  
COLOR white AGE AT LAST BIRTHDAY 29 (Years)  
BIRTHPLACE Japan  
OCCUPATION HousewifeNumber of child of this mother, including present birth. 6Number of children of this mother now living, including present birth. 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE \*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

(Physician or midwife)

Given names added from a supplemental report.

Address \_\_\_\_\_

Filed \_\_\_\_\_

1922

Registar



RECEIVED  
JUL 20 1922  
BUREAU OF VITAL  
STATISTICS

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

JUL 13 1922

Boise, Idaho, .....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place { City *Tupsee* .....  
of { Street .....  
Birth { County *Bannock* .....  
Sex of Child ..... Male  
Father *Asataro Hashimoto* ..... Full Name  
Mother *Mikiyo Hashimoto* ..... Full Maiden Name  
Date of Birth *May 24* ..... 1922  
File Number *101847* .....  
Registration Dist. No. ....

I HEREBY CERTIFY that the child described herein has been named:

*Asao Hashimoto* .....  
Child's Name in Full

*Asataro Hashimoto* .....  
Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
 BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

Birth registration is part of every child's birthright.  
 It establishes legally the date of the child's birth, parentage  
 and legitimacy.  
 It enables the Public Health Nurse to make sure the child has  
 been protected from danger of blindness and other infections at birth.  
 - - - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just ~~at~~ this time while many of the Ex-Service men are com-

pelled to furnish certified copies of certificates of birth, it is im-  
 portant that the certificates be filed with the BUREAU OF VITAL STATIS-  
 TICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

## CERTIFICATE OF DEATH.

38351

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

Registration District No. 28

County of Basia

Primary Registration District No. 2161

City of Pocatello

St.)

File No. 51

Registered No. 3847

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Hashimoto.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

male

## 4. COLOR, OR RACE

Japanese

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

## 6. DATE OF BIRTH.

May 23 1922

(Month)

(Day)

(Year)

## 7. AGE

Still Born

If LESS than 1 day how many.....hrs. or.....min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

None.

## 9. BIRTHPLACE

(State or Country)

Pocatello.

## 10. NAME OF FATHER

Asahio Hashimoto.

## 11. BIRTHPLACE OF FATHER

(State or Country)

Japan.

## 12. MAIDEN NAME OF MOTHER

Mikio Hisatomi

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Japan.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

D. Hashimoto.

(Address)

139 B 3rd City

## 15.

Filed

5-24 1922

1922

D. Hashimoto.

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 23 1922

(Month)

(Day)

(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

191 to 191, that I last saw him alive on Still Born 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still Birth.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. F. Loring M.D.

1922 (Address) Pocatello Idaho  
State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt View Cemetery May 24 1922

## 20. UNDERTAKER

ADDRESS

J. F. McMan Pocatello

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary man, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



763-214-003-156  
PLACE OF BIRTHSTATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bannock RECEIVED  
City of Pocatello JUN 22 1922  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 28 File No. 78  
Hospital Pocatello Primary Registration District No. 2161 Registered No. 4359

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>X</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>4. 14</u> 192 <u>2</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? none - sterileNumber of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER		MOTHER	
FULL NAME <u>Edward J. Potter</u>	FULL MAIDEN NAME <u>Mabel Jeffery</u>	FULL NAME <u>Mabel Jeffery</u>	FULL MAIDEN NAME <u>Mabel Jeffery</u>
RESIDENCE <u>Pocatello, Idaho</u>	RESIDENCE <u>Same</u>	RESIDENCE <u>Same</u>	RESIDENCE <u>Same</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Salt Lake City</u>	BIRTHPLACE <u>Same</u>	BIRTHPLACE <u>Same</u>	BIRTHPLACE <u>Same</u>
OCCUPATION <u>Printer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ on the date above stated. (Born alive or stillborn) 8:30 P. A. M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]

(Physician or midwife) \_\_\_\_\_

Give names added from a supplemental report.

Address \_\_\_\_\_

Filed 6-1 1922

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

IO 8

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City .....  
                  { Street .....  
                  { County .....

File Number 101854 .....

Registration Dist. No. ....

RECEIVED  
JUL 26 1922

Sex of Child. Female .....

Date of Birth ..... 1922

Father ..... Full Name

Mother ..... Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Child's Name in Full

Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
 BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

Birth registration is part of every child's birthright.  
 It establishes legally the date of the child's birth, parentage  
 and legitimacy.  
 It enables the Public Health Nurse to make sure the child has  
 been protected from danger of blindness and other infections at birth.

- - - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are com-

pelled to furnish certified copies of certificates of birth. It is im-

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bannock  
City of PocatelloRegistration District No. 28  
Primary Registration District No. 2141  
(No. General 7400 St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant PatterState of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 87897  
Registered No. 3824

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female white

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

## 6. DATE OF BIRTH

Apr 14 1922  
(Month) (Day) (Year)

## 7. AGE

Still BornIF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

## 9. BIRTHPLACE

(State or Country)

Pocatello Ida

## 10. NAME OF FATHER

E. J. Patter

## 11. BIRTHPLACE OF FATHER

(State or Country)

Utah

## 12. MAIDEN NAME OF MOTHER

Mable Jaffery

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. J. Patter  
(Address) Pocatello Id

## 15.

Filed Apr 18 1922Young  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

April 14 1922  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Delivered stillborn baby to on April 14 1922 that I last saw him alive 1922and that death occurred on the date stated above, at M.  
The CAUSE OF DEATH\* was as follows:Cord twice around babies neck. Had been dead several days

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/17/22 (Address) Pocatello Id M. D.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

St. Vieve Cem. Apr 18 1922

## 20. UNDERTAKER

## ADDRESS

H. L. McMan Pocatello Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

264-223-003-993  
PLACE OF BIRTH

RECEIVED  
JUN 22 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bannock  
City of Pocatello  
No. 28 St. Registration District No. 28 File No. 18  
Hospital Pocatello Gen'l Primary Registration District No. 2161 Registered No. 4362

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child D. Twin Triplet or other?  } and  } Number in order of birth 1 Legitimate? yes Date of birth 4/23 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none  &  sterilized

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER  
FULL NAME Joseph Arthur Samms  
RESIDENCE Pocatello, Idaho

MOTHER  
FULL MAIDEN NAME Thelma Jane Rice  
RESIDENCE Same

COLOR white AGE AT LAST BIRTHDAY 21  
(Years)

COLOR white AGE AT LAST BIRTHDAY 17  
(Years)

BIRTHPLACE Baker, Oregon

BIRTHPLACE Canada

OCCUPATION Draftsman

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Steele at 11 P. M.  
on the date above stated. (Born alive or stillborn)

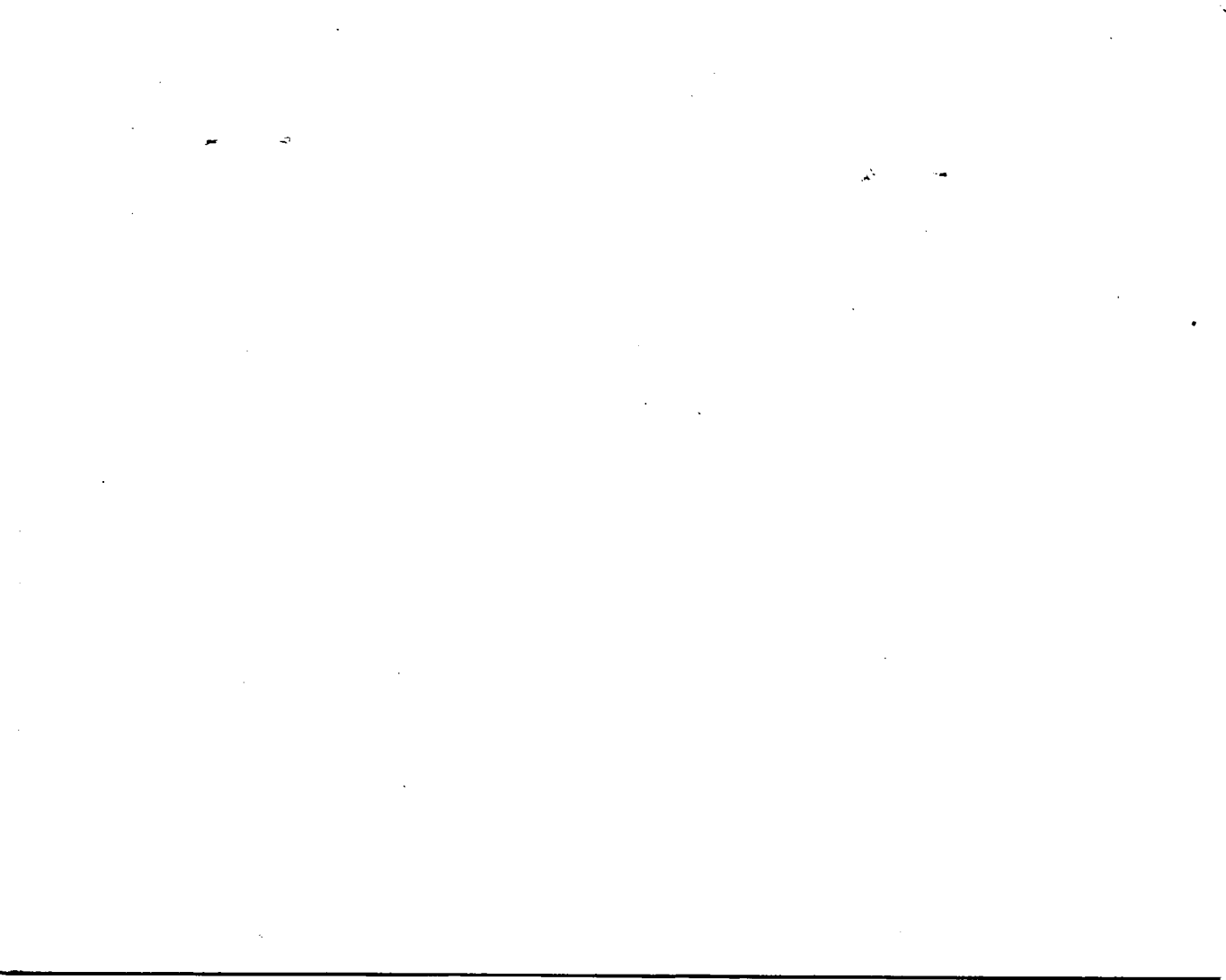
\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. May

(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address \_\_\_\_\_  
Filed 6-1 1922 \_\_\_\_\_  
Registrar.





FORM V. S. No. 5-25 M. 1-19.

## 1. PLACE OF DEATH

County of *Lincoln*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

## RECEIVED CERTIFICATE OF DEATH

Register District No. *28*Primary Registration District No. *7161*

BUREAU OF VITAL STATISTICS

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *27902*Registered No. *3831*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

*Infant daughter Ralph Samuels*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word.)

6. DATE OF BIRTH

(Month) *April*(Day) *23*(Year) *1922*

7. AGE

*Still Born*

Yrs. Mos. ds.

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

*None.*

9. BIRTHPLACE

(State or Country)

*Pocatello*

10. NAME OF FATHER

*Ralph A. Samuels*

11. BIRTHPLACE OF FATHER

(State or Country)

*Baker Oregon*

12. MAIDEN NAME OF MOTHER

*Phyllis Rice*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Canada*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Ralph A. Samuels**Pocatello*

15.

Filed

*4/24 1922**J. Young*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) *April*(Day) *23*(Year) *1922*

17. I HEREBY CERTIFY, That I attended deceased from

*April 23 1922 to April 23 1922*that I last saw her *on April 23 1922*and that death occurred on the date stated above, at *11:30 P.*

The CAUSE OF DEATH\* was as follows:

*Stillborn*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

*Good twice around neck*

(Duration) Yrs. mos. ds.

(Signed)

M. D.

*4/24 1922* (Address) *Pocatello, Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Two weeks**4/25 1922*

20. UNDERTAKER

ADDRESS

*P. J. Walker**Pocatello*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

693-214-003-631  
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
JUN 22 1922  
BUREAU OF VITAL STATISTICS

S

101869

County of Bannock  
City of Chesterfield  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Registration District No. 84 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2161 Registered No. \_\_\_\_\_  
FULL NAME OF CHILD Baby Oten (still born)  
(Certificate of no value without full name of child.)

Sex of Child <u>2</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>5-14</u> 192 <u>2</u> (Month) (Day) (Year)
-----------------------	-----------------------------------	-----------------------------------	------------------------	--

What bacteriocidal solution was used in eyes? 0

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FULL NAME <u>Harbert Oten</u>	FULL MAIDEN NAME <u>Savema Blanger</u>
RESIDENCE <u>Chesterfield</u>	RESIDENCE <u>Ches.</u>
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Chesterfield</u>	BIRTHPLACE <u>Wellsville Wal</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Hew</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

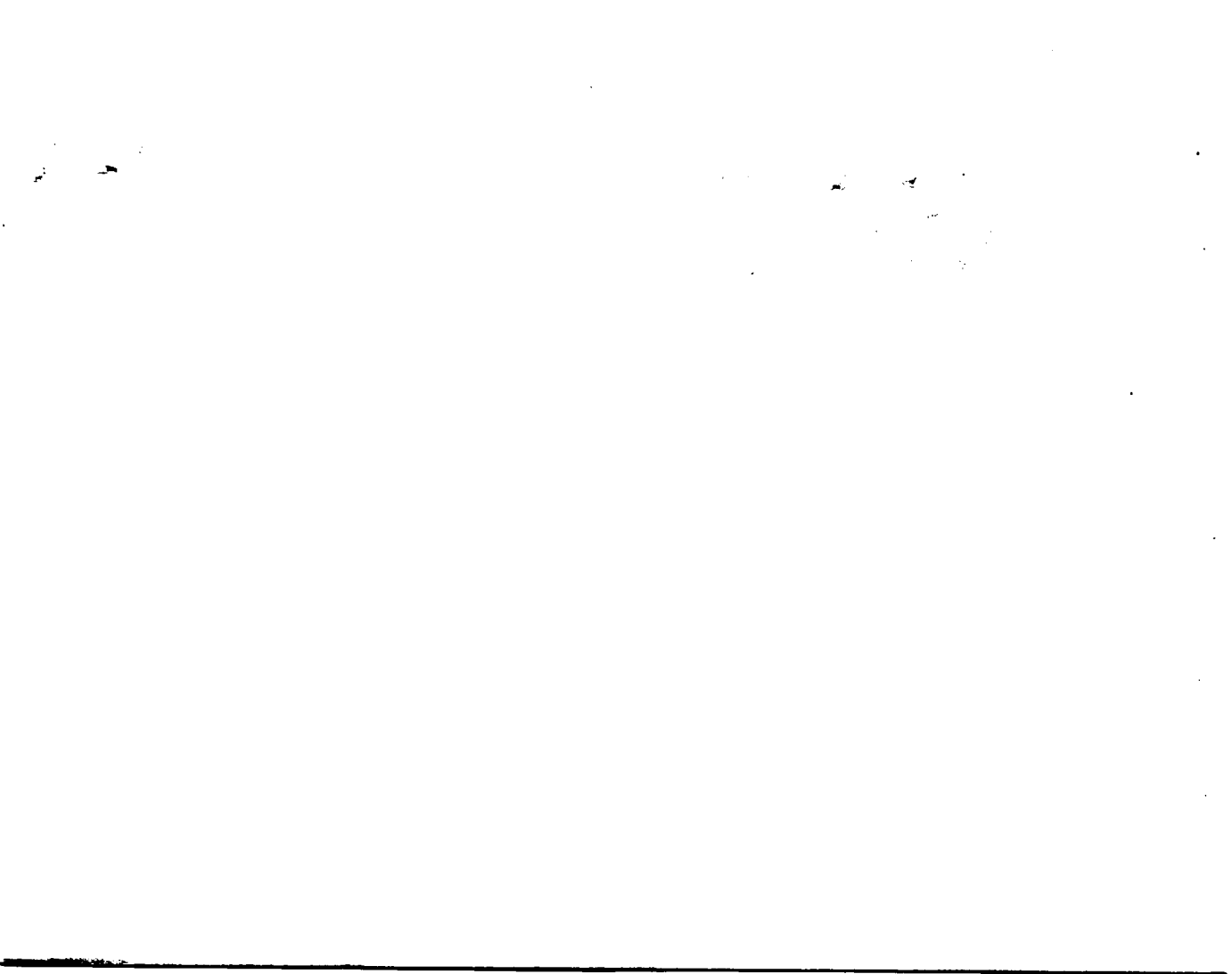
I hereby certify that I attended the birth of this child, who was Still born at 1 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Walter H. B.  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Bannock  
Filed 6-1 1922 Walter H. B.  
Registrar.



## CERTIFICATE OF DEATH

38356

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of BannockCity of ChesterfieldRegistration District No. 84Primary Registration District No. 2161

File No. ....

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby OrtonIf death occurred in a hospital, institution or camp, give its NAME instead of street and number. 1876

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

F

## 4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

5-14-22

(Month)

(Day)

(Year)

## 7. AGE

Yrs. Mos. da.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Chesterfield10. NAME OF  
FATHERDelbert Orton11. BIRTHPLACE  
OF FATHER

(State or Country)

Chesterfield12. MAIDEN NAME  
OF MOTHERLaverna Flanger13. BIRTHPLACE  
OF MOTHER

(State or Country)

Wellsville

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed 6-1-22 19.....Walt S. Pack  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 14-22

(Month)

(Day)

(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory prolonged labor  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Walt S. Pack M. D.6-1-22 (Address) Bannock

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Chesterfield

## DATE OF BURIAL

5-18-22

## 20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

296-101-003-819  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

101875

County of Bannock

City of Pocatello

No. 708 So Main St.

Hospital \_\_\_\_\_

Registration District No. 28

File No. \_\_\_\_\_

County Registration District No. 2161

Registered No. 4392

FULL NAME OF CHILD

Stell born

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	<u>Twin</u> Triplet or other?	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>5/1/1922</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FULL NAME FATHER  
E Broadhead

FULL MAIDEN NAME MOTHER  
Pillie Harwood

RESIDENCE Pocatello

RESIDENCE same

COLOR W AGE AT LAST BIRTHDAY 24  
(Years)

COLOR W AGE AT LAST BIRTHDAY 20  
(Years)

BIRTHPLACE Utah

BIRTHPLACE Utah

OCCUPATION Machinist helper

OCCUPATION hus

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was dead at 4:15 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

J P Young

(Physician or midwife)

Give names added from a supplemental report.

Address

Pocatello Idaho

Filed

7/1 1922

Registrar.

Registrar.

CLAGI TO [REDACTED]

**জাতিসংঘ**

1. What is the purpose of the document?

to work  
...  
...

1999

丁巳仲夏月  
丁巳仲夏月  
丁巳仲夏月

44-38861-1075

SECRET

14. STANDARDIZATION OF THE DATA

1990年12月

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*[Illegible text]*

\_\_\_\_\_

**UNITED STATES DEPARTMENT OF JUSTICE**

14-00000

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... ..

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\_\_\_\_\_

CHRYSLER CREDIT

[illegible]

1. 1. The first step in the process of the

**THE**

10. This document is not to be distributed outside the following:

2025 RELEASE UNDER E.O. 14176

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

100

...and the other is the fact that the ...

~~CONFIDENTIAL - SECURITY INFORMATION~~

[illegible]

\_\_\_\_\_

\_\_\_\_\_

100

REPORT OF THE BOARD OF DIRECTORS OF THE NATIONAL ASSOCIATION OF REALTORS FOR THE YEAR 1964



WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

38347

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

County of *Bannock*  
City of *Pocatello*Registration District No. *28*  
Primary Registration District No. *2161*  
St.)File No. *50*  
Registered No. *354*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Infant Broadhead.*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *single*  
(Write the word.)

6. DATE OF BIRTH.

*May 1 1922*  
(Month) (Day) (Year)

7. AGE

*still birth**0* Yrs. *0* Mos. *0* ds.IF LESS than 1 day  
how many *0* hrs. or  
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)*none*

9. BIRTHPLACE

(State or Country) *Pocatello Idaho.*

10. NAME OF FATHER

*Elijah Broadhead.*

11. BIRTHPLACE OF FATHER

(State or Country) *Aurora Utah.*

12. MAIDEN NAME OF MOTHER

*Elena Wheeler*

13. BIRTHPLACE OF MOTHER

(State or Country) *Menden Utah.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Elijah Broadhead.*  
(Address) *708 So Main St.*

15.

Filed

*9/2**1922*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*May 1 1922*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw her alive on *dead 9/1* 19122  
and that death occurred on the date stated above, at *4:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Still born in uterus.*(Duration) Yrs. mos. ds.  
Contributory *Quot in cord.*  
(Secondary)(Duration) yrs. mos. ds.  
(Signed) M. D.  
19 (Address)

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*In home**May 2 1922*

20. UNDERTAKER

ADDRESS

*V. F. McMan**215 So Main Pocatello Idaho*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

285-125-003-443  
PLACE OF BIRTH

RECEIVED  
JUL 8 1922  
BUREAU OF VITAL STATISTICS

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

County of Bannock

City of Porter

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. \_\_\_\_\_

28

File No. \_\_\_\_\_

101892

Hospital St. Anthony

Primary Registration District No. \_\_\_\_\_

1161

Registered No. \_\_\_\_\_

4409

FULL NAME OF CHILD

Michael Daniel Sheldon

(Certificate of no value without full name of child.)

Sex of Child

Male

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti-  
mate?

yes

Date of  
birth

May 25 1922

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? \_\_\_\_\_

1% Ag No 3

Number of child of this mother, including present birth \_\_\_\_\_

Number of child of this mother now living, including present birth \_\_\_\_\_

FULL  
NAME

FATHER

Wm Sheldon

FULL  
MAIDEN  
NAME

MOTHER

Mina Mullen

RESIDENCE

Porter

RESIDENCE

Porter

COLOR

W

AGE AT LAST  
BIRTHDAY

39

(Years)

COLOR

W

AGE AT LAST  
BIRTHDAY

26

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Idaho

OCCUPATION

Clerk C. S. L.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ on the date above stated.

Stillborn

(Born alive or stillborn)

7 A M.

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

Wm Brothers

(Physician or midwife)

Give names added from a supplemental report.

Address \_\_\_\_\_

Porter, Idaho

Filed \_\_\_\_\_

7/1 1922

J. H. Jones

Registrar.

Registrar.

1011

## CERTIFICATE OF DEATH

38353

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Bainbridge Registration District No. 28  
City of Pocatello Primary Registration District No. 2161  
(No.        St.)File No. 51Registered No. 3849

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Sheldon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE MARRIED, WID-  
OWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

May 25 1922  
(Month) (Day) (Year)

## 7. AGE

Still Born  
Yrs. Mos. ds. IF LESS than 1 day  
how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country) Utah

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Sheldon  
(Address) 915 W. Jander

## 15.

Filed 5-25 1922 L. R. Young  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 25 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

May 25 1922 to May 25 1922  
that I last saw him alive on May 25 1922  
and that death occurred on the date stated above, at        M.

The CAUSE OF DEATH\* was as follows:

Still Birth  
(Duration) Yrs. mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. W. Brothers M. D.May 25 1922 (Address) Pocatello, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Mountain View May 25 1922

## 20. UNDERTAKER

Schumacher Bros City

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

253-105-003-432  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bannock  
City of Pocatello

CERTIFICATE OF BIRTH **101910**

No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 28 File No. 79  
Hospital General Primary Registration District No. 2141 Registered No. 4427

FULL NAME OF CHILD

Still born

(Certificate of no value without full name of child.)

Sex of Child <u>m</u>	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>6-5-1922</u> (Month) (Day) (Year)
-----------------------	--	-----	--------------------------------	-----------------------------	--

What bacteriocidal solution was used in eyes? .....

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>W. Victor Beckstead</u>	FULL MAIDEN NAME	<u>Jemima Mc Kay</u>
RESIDENCE	<u>Pocatello</u>	RESIDENCE	<u>Pocatello</u>
COLOR	<u>wh</u>	COLOR	<u>wh</u>
AGE AT LAST BIRTHDAY	<u>25</u> (Years)	AGE AT LAST BIRTHDAY	<u>24</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>R.R. Clerk</u>	OCCUPATION	<u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was.....  
on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

....., 19.....

Registrar.

.....  
(Born alive or still born) 10:10 P. M.  
(Signature) D. C. Ray m d

.....  
(Physician or midwife)  
Address Pocatello Idaho  
Filed 7/1 1922 J. Young Registrar.

[illegible]



FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

38331

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 28  
County of Bannock JUL 14 1922  
Primary Registration District No. 1461  
City of Pocatello (State) IdahoFile No. 51Registered No. 3855

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

Baby Beckstead

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

## 6. DATE OF BIRTH

June 5 1922  
(Month) (Day) (Year)

## 7. AGE

Still BornIF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Pocatello Idaho

## 10. NAME OF FATHER

W. Victor Beckstead

## 11. BIRTHPLACE OF FATHER

(State or Country)

Proud Utah

## 12. MAIDEN NAME OF MOTHER

Jemima McKay

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Malad Ida

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. Victor Beckstead

(Address)

Pocatello Idaho

## 15.

Filed 6 6 19 22

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

1848

## 16. DATE OF DEATH

June 2 22  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

4/5 19 22 to 6-5 19 22that I last saw him alive on dead 6-5 19 22

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Sudden when one week ago  
Uremia

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

D. E. Ray

M. D.

4/6 19 22 (Address) Pocatello

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Malad Ida6-6 19 22

## 20. UNDERTAKER

## ADDRESS

D. E. JohnsonMalad

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Blaine JUL 1 1922  
City of Tringle BUREAU OF VITAL STATISTICS  
No. 566-209-004-919 Registration District No. 52 File No. 101941  
Hospital 6 Primary Registration District No. 2186 Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_  
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>3-9</u> 192 <u>2</u> (Month) (Day) (Year)
What bactericidal solution was used in eyes? _____					

Number of child of this mother, including present birth... <u>1</u>	Number of children of this mother now living, including present birth... <u>1</u>
FULL NAME <u>FATHER</u> <u>I. B. Vorland</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>V. U. Henrioth</u>
RESIDENCE <u>Tringle</u>	RESIDENCE <u>Tringle</u>
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Tringle</u>	BIRTHPLACE <u>Utah</u>
OCCUPATION <u>Lofer</u>	OCCUPATION <u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. F. ...  
Physician  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 192\_\_\_\_\_  
Registrar.

Address Montpelier  
Filed 6-28 1922 H. H. ...  
Registrar.

GENERAL P. 2

(Continued from page 1)

THIRD J.

701

OTHER

TRAIL & L.

80-8

80-8

80-8

80-8

80-8

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Dinger*  
Street  
County *Bear Lake*

File Number *101941*

Registration Dist. No. ....

Sex of Child *Female* Date of Birth *March 9* 192*2*

Father *Seamer B. Nowland* Mother *Virginia Harrio*  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Seamer B. Nowland*  
Child's Name in Full

*Seamer B. Nowland*  
Signature of Father or Mother

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage legitimacy.

It enables the Public Health Nurse to make sure the child has protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are coming to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of

Blaine

RECEIVED  
JUL 1 1922

CERTIFICATE OF BIRTH

City of

Granger

BUREAU OF VITAL

No.

818-211-004-92

St.

STATISTICS

District No.

52

File No.

101943

Hospital

Primary Registration District No.

2136

Registered No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child

Female

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti-  
mated?

Yes

Date of  
birth

3-11

1922

What bactericidal solution was used in eyes?

Argual 5.70

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

FULL  
NAME

FATHER

Margaret Hays

RESIDENCE

Granger

COLOR

W

AGE AT LAST  
BIRTHDAY

33

(Years)

BIRTHPLACE

Granger

OCCUPATION

Farmed

FULL  
MAIDEN  
NAME

MOTHER

Mrs. Wassmuss

RESIDENCE

Granger

COLOR

W

AGE AT LAST  
BIRTHDAY

31

(Years)

BIRTHPLACE

Bloomington

OCCUPATION

W

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Stillborn 11 P. M.

(Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Edith Ashley

(Physician or midwife)

Give names added from a supplemental report.

Address

Montpelier, Idaho

Filed

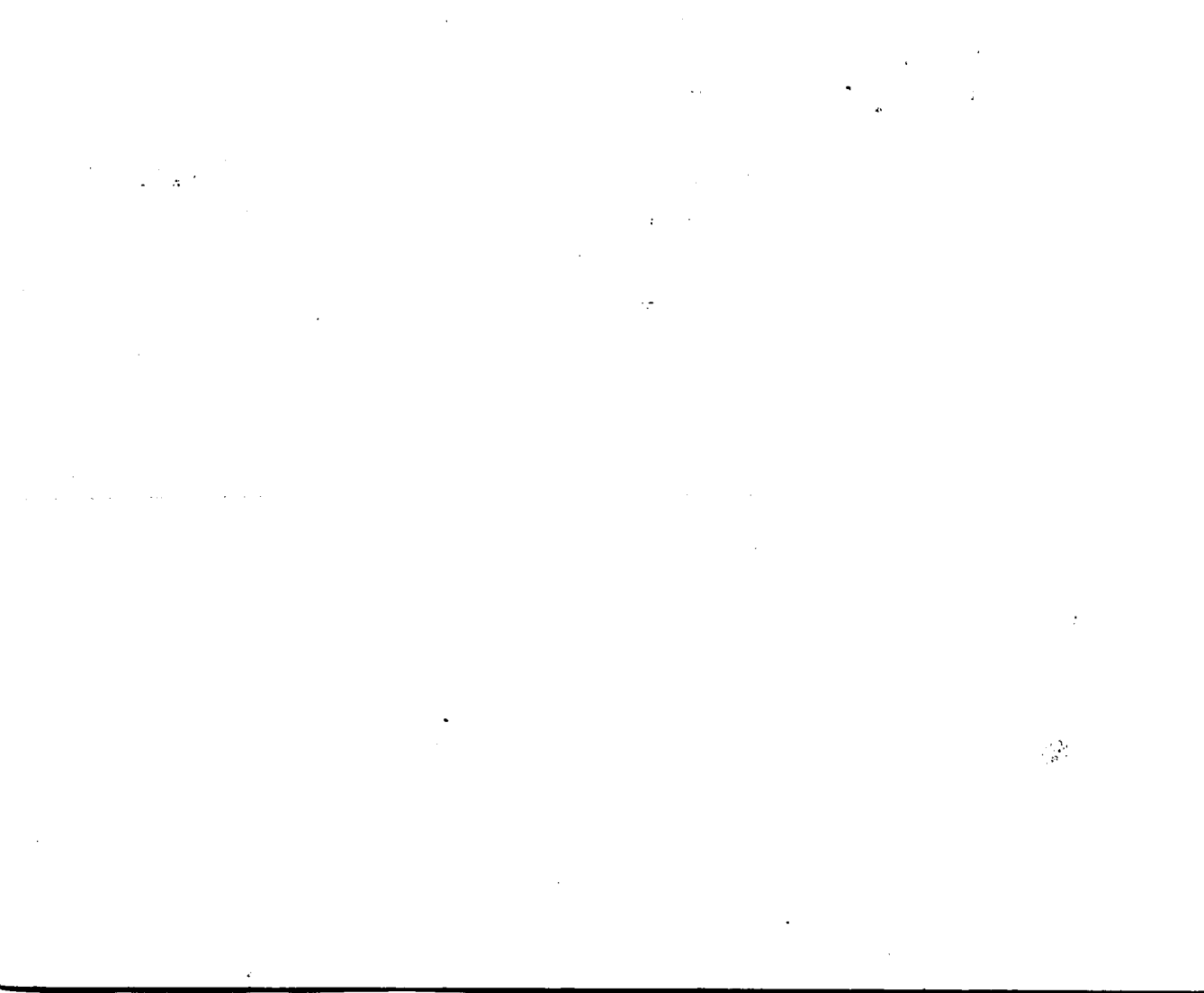
6-28

192

W. H. King

Registrar.

Registrar.





693-108-004-819

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of Bear LakeCity of St. Charles

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2136File No. 101952

Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>4-8</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	-----------------------------	--

What bacterioidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

FULL NAME <u>Clifford Williams</u>	FATHER
RESIDENCE <u>St. Charles</u>	
COLOR <u>w</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)

BIRTHPLACE <u>Paris</u>
OCCUPATION <u>farmer</u>

FULL MAIDEN NAME <u>General Fairman</u>	MOTHER
RESIDENCE <u>St. Charles</u>	
COLOR <u>w</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)

BIRTHPLACE <u>St. Charles</u>
OCCUPATION <u>wife</u>

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 11 10 M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. \*A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

\_\_\_\_\_, 192\_\_\_\_

Registrar.

(Signature)

Address \_\_\_\_\_

Filed 6-28 1922

Registrar.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

OFFICE OF THE ATTORNEY GENERAL

CLERK

1940

NOTICE

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NOTICE

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NOTICE

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NOTICE

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NOTICE

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NOTICE

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NOTICE

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NOTICE

1940

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

## BUREAU OF VITAL STATISTICS.

Place of Birth { City *St. Charles*  
 Street .....  
 County *Bear Lake*

File Number *101952*

Registration Dist. No. ....

Sex of Child *Male*Date of Birth *April 8* 192*2*Father *Clifford Williams*  
Full NameMother *Geneva Haurup*  
Full Maiden Name

HEREBY CERTIFY that the child described herein has been named:

*Baby was dead at birth so was not named*  
 Child's Name in Full

*Geneva Haurup Willia*  
 Signature of Father or Mother

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

245-118-004-397  
PLACE OF BIRTHSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-8-17

## CERTIFICATE OF BIRTH

County of *Bear Lake*City of *Georgetown*

No. .... St.

Registration District No. ....

Primary Registration District No. *2136*File No. *101957*

Registered No. ....

Hospital .....

FULL NAME OF CHILD .....

Sex of Child <i>Male</i>	Twin Triplet or other? <i>and</i>	Number in order of birth <i>1</i>	Legitimate? <i>yes</i>	Date of Birth <i>April 19 1922</i>
(To be answered only in event of plural births)				(Month) (Day) (Year)

FULL NAME <i>Isaac Koeven</i>	FATHER
RESIDENCE <i>Georgetown, Idaho</i>	
COLOR <i>white</i>	AGE AT LAST BIRTHDAY <i>30</i> (Years)
BIRTHPLACE <i>Montpelier, Idaho</i>	
OCCUPATION <i>Farmer</i>	

FULL MAIDEN NAME <i>Emma Van Arman Piffets</i>	MOTHER
RESIDENCE <i>Georgetown, Idaho</i>	
COLOR <i>white</i>	AGE AT LAST BIRTHDAY <i>25</i> (Years)
BIRTHPLACE <i>Georgetown, Idaho</i>	
OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth *4*Number of children of this mother now living, including present birth *3*

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *still born* at *11:15 P. M.* on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *Emma W. Clark*  
*Midwife*  
 (Physician or midwife)

Given names added from a supplemental report.

Address *Georgetown, Idaho*  
*6-25-22*  
 Filed *19*  
 Registrar *H. H. Kueg*  
 Registrar

2012

03112 70-501 21547

**SECRET**

157

**附註：**

**WISCONSIN**

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一、二、三、四

STANLEY

**PHYSICIAN OR MIDWIFE**

4-7-1963 30 10 11 1963

**Abstract**

TO THE HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES  
OF THE STATE OF NEW YORK:  
IN SENATE, January 11, 1911.  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE,  
IN ANSWER TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 11, 1910.

249-101-004-859

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of

Bear Lake

City of

Montpelier

No.

St.

Registration District No.

CERTIFICATE OF BIRTH

File No.

101972

Hospital

Primary Registration District No.

2136

Registered No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child

Boy

Twin  
Triplet  
or other?and  
Number  
in order  
of birth

(To be answered only in event of plural births)

Legitimate?

Yes

Date of birth

6 1

1922

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

8

Number of children of this mother now living, including present birth

8

FULL NAME

FATHER

RESIDENCE

COLOR

W

AGE AT LAST BIRTHDAY

44

BIRTHPLACE

Salt Lake City

OCCUPATION

Labor

FULL MAIDEN NAME

MOTHER

RESIDENCE

COLOR

W

AGE AT LAST BIRTHDAY

44

BIRTHPLACE

Montpelier

OCCUPATION

Nurse

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was

still

at (Born alive or stillborn)

M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. J. L. Fisher  
Physician

(Physician or midwife)

Give names added from a supplemental report.

Address

Montpelier, Ida  
6-28-1922

Filed

1922

Registrar.

Registrar.

Dep of 1922-103586



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

763-113-006-665

PLACE OF BIRTH

RECEIVED  
JUL 1 1926

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S

County of Bingham

City of Shelly

Registration District No. 131

File No. 102042

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2194 Registered No. 375

Hospital \_\_\_\_\_

FULL NAME OF CHILD John Gold

Sex of Child <u>Male</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>June 18 1922</u> (Month) (Day) (Year)
--------------------------	---	-----	-----------------------------------	------------------------	---

FULL NAME <u>Frank E. Gold</u>	FATHER	FULL MAIDEN NAME <u>Mary Barbara Workman</u>	MOTHER
RESIDENCE <u>Shelly Ida.</u>		RESIDENCE <u>Shelly Ida.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Soda Springs Ida.</u>		BIRTHPLACE <u>Bigden Utah</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 3:20 AM.  
on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature) S. R. Egbat

(Physician or midwife)

Address Shelly Idaho.

Filed 1926

Registrar

Registrar

CHUCK TO STATE  
BUREAU OF VITAL STATISTICS  
STATE OF MICHIGAN

ON THE

Notwithstanding

起

44

Primary Election District No. 1 Registered No. 1

istigati

REF ID: A66541

## Child Sex

**1992**

NEW  
1942

has

7-10-68

(continued)

## Training

**Q**

**2010**

**MOTHER**

JUL  
30 AM  
3 30 PM

3012300833

AGE AT LAST

12

REF ID: A66082

**TRAITA 354**

(b)(7)(D)

# SCIENCE

**Abstract**

819474

01749000

of child of this mother, including himself

DECLASSIFICATION OF A

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I found out that I attended the birth of this child, who was

on the above subject.

is completely worthless on any other matter.  
The Government is not at all interested  
in this matter. A number of other people  
are interested in the matter and they are  
trying to get it out of the Government.

~~Foreign Information Bureau of Soviet Intelligence Service~~

**SECRET**

**4041**

## Background

**Latvian**

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 05-11-2010 BY 60322 UCBAW

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Benjamin

Registration District No. 131

County of

Primary Registration District No. 2194

City of

Shelley

(No. 11)

St.)

Registered No. 102

If death occurs away from usual residence, give full information for under special information.

## 2. FULL NAME

John Gold

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant  
(Write the word.)

## 6. DATE OF BIRTH

June 13 1922  
(Month) (Day) (Year)

## 7. AGE

Stillborn

IF LESS than 1 day  
how many.....hrs.  
or.....min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

## 9. BIRTHPLACE

(State or Country)

Shelley Ida.

## 10. NAME OF FATHER

Frank E. Gold.

## 11. BIRTHPLACE OF FATHER

(State or Country)

Soda Springs Ida

## 12. MAIDEN NAME OF MOTHER

Mary Barbara Woolstone

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Ogden Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Shelley Idaho

## 15. Filed

June 27 1922 Mother &amp; Father

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

June 13 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1922 to June 13 1922 that I last saw h. alive on June 13 1922 and that death occurred on the date stated above, M.

The CAUSE OF DEATH\* was as follows:

Stillborn full term.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Egbert

1922

(Address)

Shelley Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

632-117-009-113

PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTHCounty of BonnerCity of Priest RiverRegistration District No. 85File No. 3

No. \_\_\_\_\_ St.

Primary Registration District No. 218Registered No. 161

Hospital \_\_\_\_\_

FULL NAME OF CHILD Carl Olson

Sex of Child

MaleTwin  
Triplet  
or other?Number  
in order  
of birth

{ and {

(To be answered only in event of plural births)

Legitimate?

Yes

Date of Birth

May 17 1922  
(Month) (Day) (Year)

FULL NAME

FATHER

Martin Oscar Olson

RESIDENCE

Priest River

COLOR

White

AGE AT LAST BIRTHDAY

25  
(Years)

BIRTHPLACE

Id.

OCCUPATION

Laborer

FULL MAIDEN NAME

MOTHER

Helen Dorothy Jackson

RESIDENCE

Priest River

COLOR

White

AGE AT LAST BIRTHDAY

17  
(Years)

BIRTHPLACE

Idaho

OCCUPATION

HousewifeNumber of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Shelton at 10 A M.  
(Born alive or stillborn)

(Signature)

G. P. Gelfin

(Physician or midwife)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

19.

Address

Priest River

Filed

June 1 1922 G. P. Gelfin  
Registrar.

Registrar.

must be made for each one child at birth a SEPARATE RETURN and the number of each, in order of birth stated.

STATE OF NEW YORK  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

105033

File No.

Registration District No.

Registered No. 104

Primary Registration District No. 318

No. 81

Hospital

Full Name of Child: *Male*  
Date of Birth: *July 15, 1904*  
Place of Birth: *St. Louis, Mo.*

Father: *Marion Lee Oliver*  
Mother: *Leola Pearl Oliver*

Residence: *St. Louis, Mo.*

Color: *White*  
Age at Last Birthday: *1*

Birthplace: *St. Louis, Mo.*

Occupation: *Housewife*

Number of child of this mother: *1*  
Number of children of this mother now living: *1*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
born on the *15th* day of *July*, 1904.

When there was no attending physician or midwife present the father, grandfather, etc., should make this return. A midwife, who is one that delivers women, may appear when called upon at this time.

Given when called upon a sworn statement.

Address: *St. Louis, Mo.*  
Filed: *July 15, 1904*

NOT TO BE FILLED IN BY THE REGISTRAR  
COUNTY OF *St. Louis*  
CITY OF *St. Louis*  
WARD OF *St. Louis*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

 38402 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Bonneville*City of *Boise*Registration District No. *8*Secondary Registration District No. *485*(No. *1518*)

St.)

File No. *2*Registered No. *63*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Carl Olson*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*M*

## 4. COLOR OR RACE

*W.*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Single*  
(Write the word.)

## 6. DATE OF BIRTH

*May 17 1922*  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

 IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*Martin Olson*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Idaho*

## 12. MAIDEN NAME OF MOTHER

*Helen Jackson*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Walter Oscar Olson*

(Address)

## 15.

Filed

*June 1 1922*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*May 17 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Stiel Burn*

(Duration) Yrs. mos. ds.

 Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

*E. P. Getz*  
M. D.

June 1 1922 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



864-218-014-753  
PLACE OF BIRTHSTATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of

Canyon

City of

Notus

No.

St.

Registration District No.

3

File No.

102197A

Hospital

Primary Registration District No.

2005

Registered No.

102

FULL NAME OF CHILD

one stillborn, then died 3 hrs later.

(Certificate of no value without full name of child.)

Sex of Child	both female	Twin	Twins or other?	and	Number in order of birth	9	Legitimate?	yes	Date of birth	May 18	1922
									(Month)	(Day)	(Year)

What bactericidal solution was used in eyes? 1% col. Nitrate Silver

Number of child of this mother, including present birth... 9... Number of child of this mother now living, including present birth... 7...

FULL NAME FATHER L. E. Hodson FULL MAIDEN NAME MOTHER Ida. Peterson

RESIDENCE Notus Ida. RESIDENCE Notus Ida.

COLOR white AGE AT LAST BIRTHDAY 37 (Years) COLOR white AGE AT LAST BIRTHDAY 39 (Years)

BIRTHPLACE El Paso Ill. BIRTHPLACE Ida.

OCCUPATION Farmer Birth. OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

One still born 9 one died 3 hrs born on above 1:30 P. M.

I hereby certify that I attended the birth of this child, who was (Born alive or stillborn)

(Signature) J. M. Henry.

(Physician or midwife)

Give names added from a supplemental report.

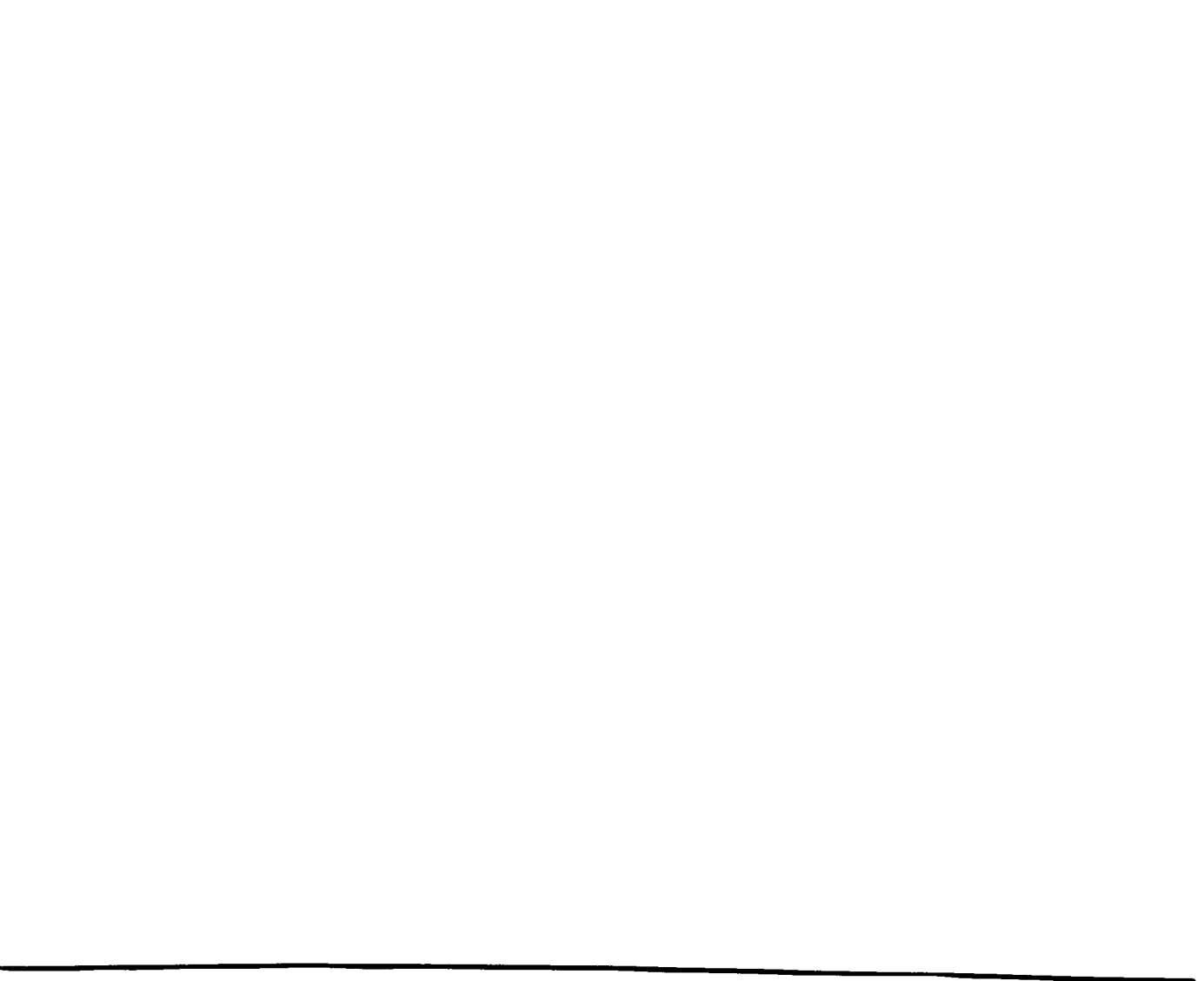
Address Caldwell Ida.

Filed May 23, 1922 John H. Meyer Registrar.

Registrar.

N. B.—In case of more than one child at birth a SEPARATE REPORT should be made for each and the number of each, in order of birth stated.

T RECORD



319-214-014-415

PLACE OF BIRTH

RECEIVED

JUN 22 1922

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-25m-6-15-18

County of Canyon

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 102211

City of ParmaRegistration District No. 2

File No.

No. \_\_\_\_\_ St.

Primary Registration District No. 2007Registered No. 32

Hospital \_\_\_\_\_

Full Name of Child Alice May Carpenter

SEX OF CHILD <u>female</u>	Twin Triplet or other? _____	{and} Number in order of birth	Legiti- mate? <u>yes</u>	DATE OF BIRTH <u>Apr. 14</u> (Month) (Day) (Year) <u>1922</u>
FATHER FULL NAME <u>M. C. Carpenter</u>			MOTHER FULL MAIDEN NAME <u>Etta Mackey</u>	
RESIDENCE <u>Parma R. 2</u>			RESIDENCE <u>Parma R. 2</u>	
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>41</u> (Years)		COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>45</u> (Years)
BIRTHPLACE <u>Oregon</u>			BIRTHPLACE <u>Iowa</u>	
OCCUPATION <u>Farmer</u>			OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth... 5..... Number of children of this mother now living, including present birth... 4.....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 12:30 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas. B. Allen

(Physician or midwife)

Given names added from a supplemental report

19

Address

Filed 6-1

1922

Registrar

Registrar

DE FILE

SEVEN

196

DEPARTMENT

Place of Birth { City Panna  
 { Street .....  
 { County Canyon

File Number .....102211.....

Registration Dist. No. ....

Sex of Child.....Female

Date of Birth April 14 1922Father Marley C. Carpenter  
 Full NameMother Etta Mackey  
 Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Alice May Carpenter  
 Child's Name in Full

Etta Carpenter  
 Signature of Father or Mother

OVER

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Canyon

Registration District No.

City of Panama Precinct

(No. ....)

St.)

File No. 38443Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carpenter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

femaleW.Single  
(Write the word.)

6. DATE OF BIRTH

April  
(Month)14  
(Day)1922  
(Year)

7. AGE

IF LESS than 1 day  
how many ..... hrs. or  
..... min.?

yrs.

mos.

ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

M. C. Carpenter

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Etta Mackey

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Carpenter(Address) Panama, Ida.

15.

Filed

6-11922Richard L. Aldridge  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

1512

16. DATE OF DEATH

April  
(Month)14  
(Day)1922  
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above at

Panama, Ida.

The CAUSE OF DEATH\* was as follows:

Premature birth, seven months

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Shoulder presentation & version

(Duration)

yrs.

mos.

ds.

(Signed)

Chas. B. Allen

M. D.

4/141922

(Address)

Panama, Ida.

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs.

mos.

ds.

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of Canyon RECEIVEDCity of Caldwell JUL 8 1922346-224-014-433-11-13-28  
No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. \_\_\_\_\_

File No. 102237

Hospital \_\_\_\_\_

Primary Registration District No. 1005 Registered No. 126FULL NAME OF CHILD Thelma Cuffs

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>June 24 22</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	----------------------------	---

FULL NAME FATHER Harry Edward CuffsRESIDENCE Caldwell, IdahoCOLOR White AGE AT LAST BIRTHDAY 38  
(Years)BIRTHPLACE Carthage, Mo.OCCUPATION Day laborer & FarmerFULL MAIDEN NAME MOTHER Marion May McCuskerRESIDENCE Caldwell, IdahoCOLOR White AGE AT LAST BIRTHDAY 36  
(Years)BIRTHPLACE Hopkins, Mo.OCCUPATION HousewifeNumber of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 5

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 7 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Carl Farmer, D.O.

(Physician or midwife)

Given names added from a supplemental report.

19

Address Caldwell, IdahoFiled June 28 1922John V. Meyer

Registrar

Registrar



**STATE OF IDAHO**  
**DEPARTMENT OF PUBLIC WELFARE**

Boise, Idaho,.....

**JUL 13 1922**

192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

---

Place of Birth { City ..... Street ..... County .....	File Number ..... <b>102237</b>  Registration Dist. No. ....  Date of Birth ..... 192...
Sex of Child..... <b>Female</b>	
Father ..... Full Name	Mother ..... Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*We were going to name the baby, if a girl; Thelma  
But she was still born. Can apply the name if needed*  
..... *Harry Edward Cripp* .....  
Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parent legitimacy.

It entitles the Public Health Nurse to make sure the child is protected from danger of blindness and other infections at birth.

IT SHOWS AT LATER PERIODS OF LIFE:

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are called to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 3  
County of Canyon Primary Registration District No. 1005  
City of Caldwell (No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby CuppFile No. 38438  
Registered No. 92

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED (Write the word.)

## 6. DATE OF BIRTH

June 24 1922  
(Month) (Day) (Year)

## 7. AGE

Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds. \_\_\_\_\_

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)None

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

H. E. Cupp

## 11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

## 12. MAIDEN NAME OF MOTHER

Florence McCaskey

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

## (Informant)

(Address)

H. E. Cupp  
Caldwell, Idaho

## 15. Filed

June 26 - 1922John H. Meyer  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

June 24 1922  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 24 1922 to June 24 1922  
that I last saw him alive on June 24 1922  
and that death occurred on the date stated above, at 7-0 M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Carl Warner, M.D.

1922

(Address)

Caldwell, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Canyon Hill6-26-1922

## 20. UNDERTAKER

## ADDRESS

W. V. BeckhamCaldwell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11—25m-1-1-18

County of CanyonCity of Caldwell

396-224-014-133

No. \_\_\_\_\_ St. \_\_\_\_\_

JUL 8 1922

Registration District No. \_\_\_\_\_

CERTIFICATE OF BIRTH

File No. \_\_\_\_\_

S

102249

Primary Registration District No. 2005Registered No. 132

Hospital \_\_\_\_\_

FULL NAME OF CHILD

CroftSex of Child Female { Twin Triplet or other? (To be answered only in event of plural births) } and { Number in order of birth } Legiti- mate? yes Date of Birth July 24 1922 (Month) (Day) (Year)FULL NAME FATHER Samuel E CroftRESIDENCE CaldwellCOLOR White AGE AT LAST BIRTHDAY 31 (Years)BIRTHPLACE UtahOCCUPATION FarmerFULL NAME MOTHER Roseline AllenRESIDENCE CaldwellCOLOR White AGE AT LAST BIRTHDAY 31 (Years)BIRTHPLACE UtahOCCUPATION H. W.Number of child of this mother, including present birth 6Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born on the date above stated. (Born alive or stillborn)

{ \*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

Given names added from a supplemental report.

(Signature)

T. D. Farner

(Physician or midwife)

Address

Caldwell Ida

Filed

July 7 1922 John H. Meyer

Registrar





STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho,.....

JUL 1 3 1922.....1922

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City .....  
                  { Street .....  
                  { County .....

File Number .....102249.....

Registration Dist. No. ....

Sex of Child.....Female.....

Date of Birth .....1922.....

Father.....Full Name.....

Mother.....Full Maiden Name.....

I HEREBY CERTIFY that the child described herein has been named:

.....  
Child's Name in Full

.....  
Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

692-216-016-792

PLACE OF BIRTH

STATE OF IDAHO

S

RECEIVED DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

JUN 22 1922

CERTIFICATE OF BIRTH

102273

County of CassiaCity of Burley

BUREAU OF VITAL

Registration District No. 117

File No.

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

Primary Registration District No. 2196Registered No. 2268FULL NAME OF CHILD Stielborn Wise

(Certificate of no value without full name of child.)

Sex of Child FTwin  
Triplet  
or other?

{ and }

Number  
in order  
of birthLegiti-  
mate? YesDate of  
birth May 16 1922

(Month)

(Day)

(Year)

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? Silver NitrateNumber of child of this mother, including present birth 11Number of child of this mother now living, including present birth 7FULL  
NAME

FATHER

F. P. WiseFULL  
MAIDEN  
NAME

MOTHER

Elizabeth Gibson

RESIDENCE

Burley

RESIDENCE

Burley

COLOR

whiteAGE AT LAST  
BIRTHDAY 49

(Years)

COLOR

whiteAGE AT LAST  
BIRTHDAY 42

(Years)

BIRTHPLACE

Neb.

BIRTHPLACE

Utah

OCCUPATION

Farming

OCCUPATION

House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. C. Patterson

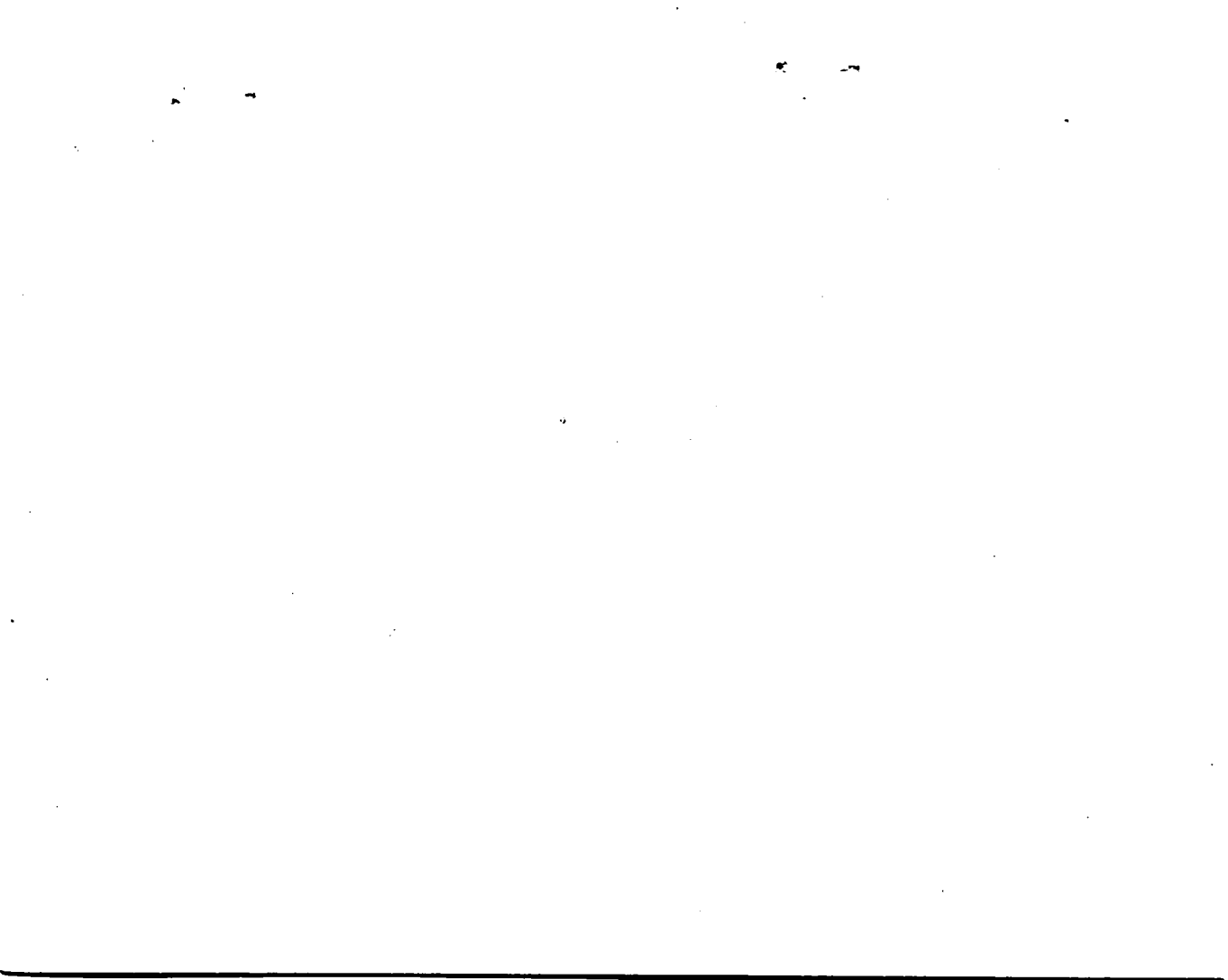
(Physician or midwife)

Give names added from a supplemental report.

Address Burley, IdaFiled May 20 1922Dr. J. C. Patterson

Registrar.

Registrar.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. **38465**  
Registered No. **587**

1. PLACE OF DEATH **Passaic** Registration District No. **117**  
 County of **Burley** Registration District No. **2196**  
 City of **Burley** (State) \_\_\_\_\_  
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Stillborn Wise**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
 (Write the word.)

6. DATE OF BIRTH **May 16 1922**  
 (Month) (Day) (Year)

7. AGE \_\_\_\_\_ IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Burley, Ida.**  
 (State or Country)

10. NAME OF FATHER **F. P. Wise**

11. BIRTHPLACE OF FATHER **Neb.**  
 (State or Country)

12. MAIDEN NAME OF MOTHER **Elizabeth Gibson**

13. BIRTHPLACE OF MOTHER **Utah.**  
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) **F. P. Wise**  
 (Address) **Burley, Ida.**

15. Filed **May 17 1922** **D. J. C. Patterson**  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **May 16 1922**  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_  
 that I last saw him alive on \_\_\_\_\_  
 and that death occurred on the date stated above, at \_\_\_\_\_ M.  
 The CAUSE OF DEATH\* was as follows:  
**Stillborn**

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory (Secondary) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) **J. C. Patterson** M. D.  
**5-16 1922** (Address) **Burley, Ida.**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL **Burley, Ida.** DATE OF BURIAL **5-16 1922**

20. UNDERTAKER **None** ADDRESS \_\_\_\_\_

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

219-104-016 - 366  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

RECEIVED  
CERTIFICATE OF BIRTH

County of Cassia

City of Burley

No. 32

Hospital St. Paul

Registration District No. 117

Primary Registration District No. 2196

File No. 102275

Registered No. 2270

FULL NAME OF CHILD

Stiel born. Barrus.

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twins Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes.</u>	Date of birth <u>May 4</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	--	---	------------------------------	--

What bactericidal solution was used in eyes? Silver Nitrate

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER		MOTHER	
FULL NAME	<u>O. L. Barrus.</u>	FULL MAIDEN NAME	<u>Maud Cook.</u>
RESIDENCE	<u>Burley, Ida.</u>	RESIDENCE	<u>Burley, Ida.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>43</u> (Years)	AGE AT LAST BIRTHDAY	<u>43</u> (Years)
BIRTHPLACE	<u>Wantsville, Wt.</u>	BIRTHPLACE	<u>London, Eng.</u>
OCCUPATION	<u>Insurance Agt.</u>	OCCUPATION	<u>House</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Born dead at 4 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Dr. J. C. Patterson

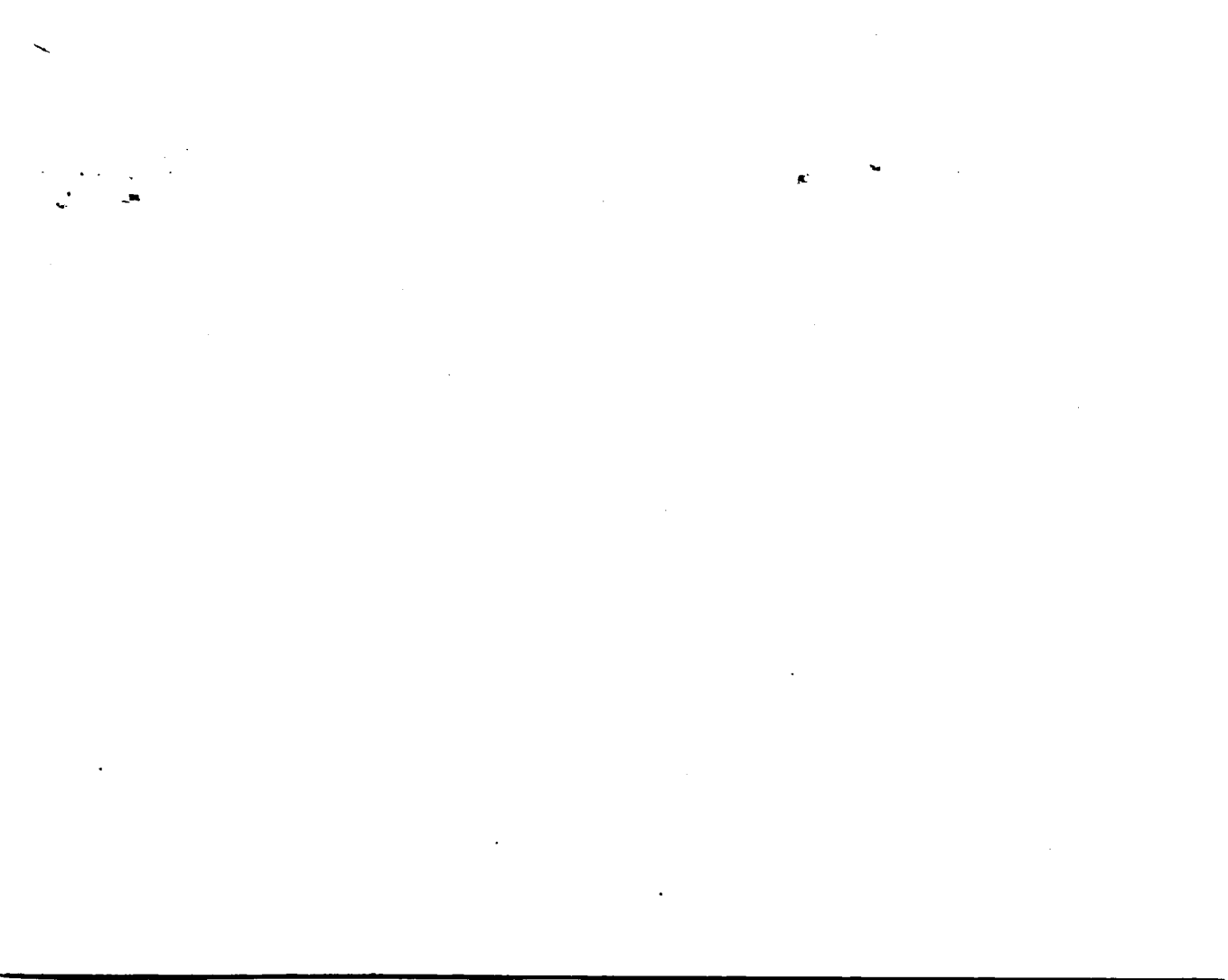
Physician  
(Physician or midwife)

Address Burley, Idaho

Filed May 18 1922 Dr. J. C. Patterson

Registrar.

Registrar.





1. PLACE OF DEATH  
 County of Cassia  
 City of Burley BUREAU OF VITAL STATISTICS  
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn Barues

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 38472  
 Registered No. 589

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single  
 (Write the word.)

6. DATE OF BIRTH May 4 1922  
 (Month) (Day) (Year)

7. AGE — Yrs. — Mos. — ds. IF LESS than 1 day how many — hrs. or — min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Burley, Ida.  
 (State or Country)

10. NAME OF FATHER O. L. Barues

11. BIRTHPLACE OF FATHER Grantsville, Ut.  
 (State or Country)

12. MAIDEN NAME OF MOTHER Maud Cook

13. BIRTHPLACE OF MOTHER London, Eng.  
 (State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. L. Barues  
 (Address) Burley, Idaho

15. Filed May 18 1922 Dr. J. C. Patterson  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 4 1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19  
 that I last saw h. alive on 19  
 and that death occurred on the date stated above, at M.  
 The CAUSE OF DEATH\* was as follows:  
Stillborn

(Duration) — Yrs. — mos. — ds.  
 Contributory (Secondary)

(Duration) — yrs. — mos. — ds.  
 (Signed) J. C. Patterson M. D.  
5-5 19 22 (Address) Burley, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burley, Ida. DATE OF BURIAL May 7 1922

20. UNDERTAKER L. B. Sallegly ADDRESS Burley, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

632-114-016-791  
PLACE OF BIRTH

County of Cassia  
City of Burley  
No. \_\_\_\_\_ St. \_\_\_\_\_

RECEIVED  
JUN 22 1922  
STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

102279

Hospital \_\_\_\_\_ Registration District No. 117 File No. \_\_\_\_\_  
Primary Registration District No. 2196 Registered No. 2274

FULL NAME OF CHILD

Stillborn Olsen

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and	Number in order of birth _____	Legiti- mate? <u>Yes</u>	Date of birth <u>May 14</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? Silver Nitrate

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 7

FULL NAME C. M. Olsen FATHER  
RESIDENCE Burley, Ida.  
COLOR White AGE AT LAST BIRTHDAY 55 (Years)  
BIRTHPLACE Denmark.  
OCCUPATION Farming.

FULL MAIDEN NAME Alice Transbury MOTHER  
RESIDENCE Burley, Ida.  
COLOR White AGE AT LAST BIRTHDAY 35 (Years)  
BIRTHPLACE Kansas.  
OCCUPATION Wife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 7 P. M.  
on the date above stated. (Born alive or stillborn)

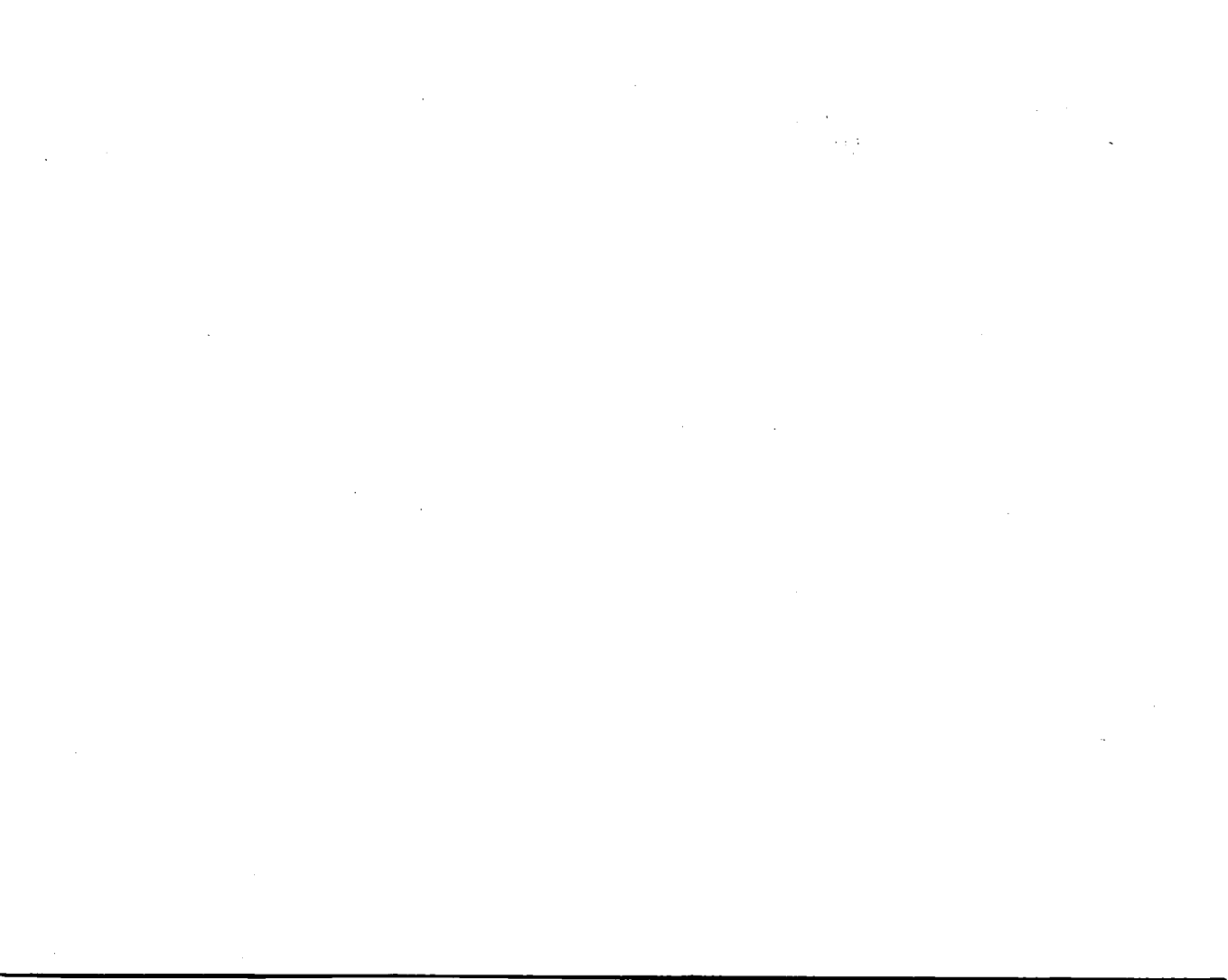
\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Dr. J. C. Patterson  
Physician  
(Physician or midwife)

Address Burley, Idaho.  
Filed May 23 1922 Dr. J. C. Patterson  
Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK- THIS IS A PERMANENT RECORD  
 N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

249-126-021-713

PLACE OF BIRTH

County of **Franklin**City of **Riverdale.**

No. .... St.

Hospital .....

FULL NAME OF CHILD .....

RECEIVED  
 JUL 1 1922  
 IDAHO DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 Registration District No. .... 2119

Form V. S. No. 11-C-25m-9-8-17  
**STATE OF IDAHO**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF BIRTH**

S

File No. **102351**

Primary Registration District No. .... 27

Registered No. **162**

Sex of Child **Male.** Twin Triplet or other? } and { Number in order of birth } Legitimate? **Yes.** Date of Birth **June 26** 19**22**  
 (To be answered only in event of plural births) (Month) (Day) (Year)

FULL NAME FATHER **Perry Walker Smith.**RESIDENCE **Riverdale Ida.**COLOR **White** AGE AT LAST BIRTHDAY **28** (Years)BIRTHPLACE **Riverdale Ida.**OCCUPATION **Farmer.**FULL MAIDEN NAME MOTHER **Delpha Walker.**RESIDENCE **Riverdale Ida.**COLOR **White.** AGE AT LAST BIRTHDAY **23** (Years)BIRTHPLACE **Riverdale Ida.**OCCUPATION **Housewife.**Number of child of this mother, including present birth... **3** Number of children of this mother now living, including present birth... **1**

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was **Stillborn.** at **4:35A.** M.  
 on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) **G. W. States**  
**Physician**  
 (Physician or midwife)

Given names added from a supplemental report.

Address **Preston Idaho.**Filed **July 3 1922** **Mrs. Ida Lyjiaelis**  
 Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

Form V. S. No. 5. 12½ M. 7-24-11 JUL 3 1922 CERTIFICATE OF DEATH

1. PLACE OF DEATH. BUREAU Registration District No. 2119  
County of Franklin Primary Registration District No. 27  
City of Riverdale (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 38432  
Registered No. 73

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White (Write the word.)

6. DATE OF BIRTH

June 26 1922  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many hrs. or min?  
yrs. mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Franklin Co Idaho

10. NAME OF FATHER

Perry W. Smith

11. BIRTHPLACE OF FATHER

(State or Country) Riverdale Idaho

12. MAIDEN NAME OF MOTHER

Alpha Packer

13. BIRTHPLACE OF MOTHER

(State or Country) Riverdale Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) G W States Preston Idaho

15.

Filed July 3 1922 Mrs H. Luppel  
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 26 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

This child born dead.  
umbilical cord strangulated

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) G W States M. D.

June 30 1922 (Address) Preston Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Riverdale Ida June 27 1922

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



## PLACE OF BIRTH

County of Idaho RECEIVED JUL 8 1922City of GrangevilleNo. 154-2018-025 St. ATLANTAPrimary Registration District No. 1001 Registered No. 31

Hospital \_\_\_\_\_

FULL NAME OF CHILD StillbirthSex of Child Female Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legit mate? yes Date of Birth 6-1-22  
(To be answered only in event of plural births) (Month) (Day) (Year)FULL NAME FATHER Samuel AndrewsRESIDENCE GrangevilleCOLOR White AGE AT LAST BIRTHDAY 26  
(Years)BIRTHPLACE Sublet Ida.OCCUPATION FarmerFULL MAIDEN NAME MOTHER Ruby Fay PriestRESIDENCE GrangevilleCOLOR White AGE AT LAST BIRTHDAY 24  
(Years)BIRTHPLACE Dayton Wm.OCCUPATION HousewifeNumber of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:00 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) B. Chipman

(Physician or midwife)

Given names added from a supplemental report.

Address Grangeville Ida.Filed July 5 1922 S. O. Stockton

Registrar

Registrar



SECRET

111

SECRET

SECRET

SECRET

SECRET

SECRET

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 38525  
Registered No. 15

## I. PLACE OF DEATH

County of Idaho  
City of BrangervilleRegistration District No. 103  
Primary Registration District No. 1001  
(No. 1001 St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

not named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-OWED OR DIVORCED  
(Write the word.)

6. DATE OF BIRTH

June (Month) 3rd (Day) 1922 (Year)

7. AGE

— Yrs. — Mos. — ds.IF LESS than 1 day  
how many — hrs.  
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ?  
(b) General nature of industry, business or establishment in which employed (or employer) ?

9. BIRTHPLACE

(State or Country) Brangerville

10. NAME OF FATHER

Samuel Anderson

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Ruby's Prest

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samy Andrews(Address) Brangerville

15.

Filed July 1 1922 J S Stockton

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 1 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw h. — alive on 19and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH\* was as follows:

Still birth(Duration) — Yrs. — mos. — ds.Contributory  
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) B Chipman

M. D.

6/1 1922 (Address) Brangerville Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prairie View6/1 1922

20. UNDERTAKER

ADDRESS

E S Hancock Brangerville

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

816-43-026-816  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Jefferson

City of Replay

No. home St.

Hospital

Registration District No. 98

File No. 102482

Primary Registration District No. 2176

Registered No. 202

FULL NAME OF CHILD Wall Hawkins

(Certificate of no value without full name of child.)

Sex of  
Child m

Twin  
Triplet  
or other?

} and

{ Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti-  
mate? Yes

Date of  
birth

4/12 19222  
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? Yes

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

FULL  
NAME

FATHER

Clarence J. Hawkins

FULL  
MAIDEN  
NAME

MOTHER

Alice V. Hawks

RESIDENCE

Replay Ida

RESIDENCE

Replay Ida

COLOR

White

AGE AT LAST  
BIRTHDAY

24  
(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

23  
(Years)

BIRTHPLACE

Bingham Ut

BIRTHPLACE

Idaho Ut

OCCUPATION

Banking

OCCUPATION

home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was

April born at 12 PM M.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

(Physician or midwife)

Give names added from a supplemental report.

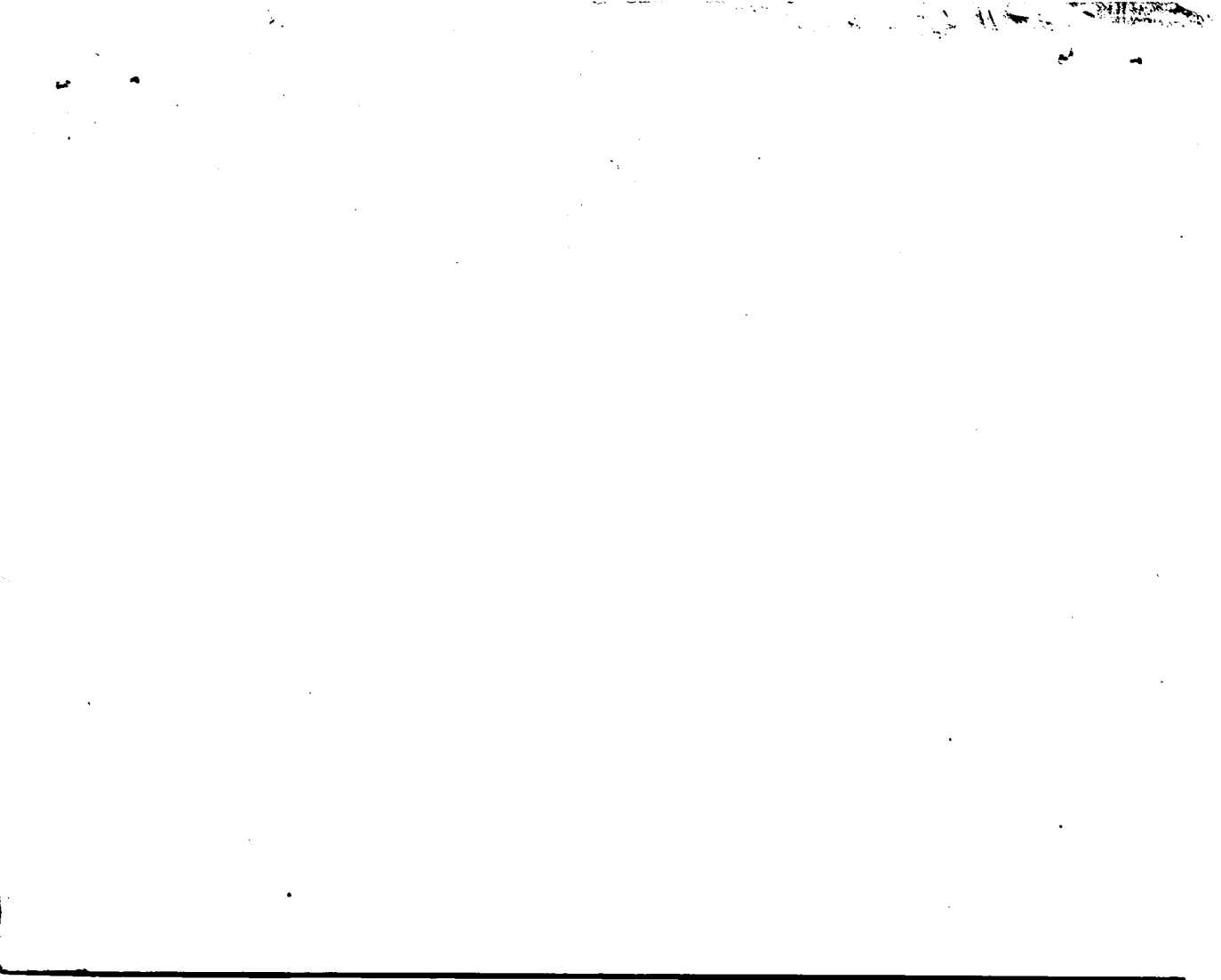
Address

Filed

192

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

RECEIVED  
JUL 1 1922

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 38529  
Registered No. 39

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.

St.)

2. FULL NAME

Baby Dale Hawkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

April

17

1922

(Month)

(Day)

(Year)

7. AGE

Still Birth

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rigby, Idaho

10. NAME OF FATHER

David J. Hawkins

11. BIRTHPLACE OF FATHER

(State or Country)

Benjamin Utah

12. MAIDEN NAME OF MOTHER

Alice V. Hawkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Jovele Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David J. Hawkins

(Address)

Rigby, Idaho

15.

Filed

6-30

19

22

Ray H. Fisher  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

12

22

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

19

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH was as follows:

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

19

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rigby Idaho

Apr 13 1922

20. UNDERTAKER

ADDRESS

Ed. G. Galt

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



1515

PLACE OF BIRTH 816-107-033-845 STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

## CERTIFICATE OF BIRTH

County of Madison  
City of Thoniton

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 100File No. 102621

Hospital \_\_\_\_\_

Primary Registration District No. 2148Registered No. 178

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of Birth <u>6-2-</u> 192 <u>2</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? 2% mercuric chromeNumber of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 8FULL NAME FATHER Chas Madison HawsFULL MAIDEN NAME MOTHER Harriet Vessie HunsakerRESIDENCE ThonitonRESIDENCE ThonitonCOLOR White AGE AT LAST BIRTHDAY 47 (Years)COLOR White AGE AT LAST BIRTHDAY 39 (Years)BIRTHPLACE UtahBIRTHPLACE UtahOCCUPATION FarmerOCCUPATION Housewife

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Laird A. Rich

(Physician or midwife)

Give names added from a supplemental report. \_\_\_\_\_, 19\_\_\_\_

Address Reeburg Ida.Filed June 1922

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

SEVERAL REASONS WHY A CHILD  
BE FILED FOR EACH CHILD

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

---

Place of Birth	City .....	File Number .....	102621
	Street .....	Registration Dist. No. ....	
	County .....		

Sex of Child.....	Male	Date of Birth .....	192....
-------------------	------	---------------------	---------

Father .....	Mother .....
Full Name	Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

.....  
Child's Name in Full

.....  
Signature of Father or Mother

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

795-113-035-613  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

102673

County of Nezperce **RECEIVED**  
City of Lewiston **JUN 22 1922**  
No. \_\_\_\_\_ St. 30 Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
FULL NAME OF CHILD Albert Lloyd Green  
(Certificate of no value without full name of child.)

Sex of Child male Twin Triplet or other? and Number in order of birth \_\_\_\_\_ Legitimate? Yes Date of birth May 13 1922  
(To be answered only in event of plural births.) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	<u>Lloyd W. Green</u>	FULL MAIDEN NAME	<u>Eloise K. Falwell</u>
RESIDENCE	<u>Lewiston Orchards</u>	RESIDENCE	<u>Lewiston Orchards</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>20</u> (Years)	AGE AT LAST BIRTHDAY	<u>20</u> (Years)
BIRTHPLACE	<u>Texas</u>	BIRTHPLACE	<u>Oklahoma</u>
OCCUPATION	<u>Rancher</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_  
on the date above stated. (Living or stillborn) l.a. M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) O. Carson

Give names added from a supplemental report. \_\_\_\_\_  
Address Lewiston, Idaho.  
Filed Jun 22 1922  
Registrar F. T. News Registrar.

OHIO 70

EVERETT PRATT, JR. CERTIFICATE OF BIRTH SP

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Lewiston* ..... File Number ..... 102673  
Street .....  
County *New Jersey* ..... Registration Dist. No. ....  
Sex of Child ..... Male ..... Date of Birth *May 13* ..... 192*2*.  
Father *Loyd William Green* ..... Mother *Elvora Hamball Falwell* .....  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Albert Loyd Green* .....  
Child's Name in Full  
*Mrs. Loyd Green* .....  
Signature of Father or Mother

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

---



## CERTIFICATE OF DEATH

concord  
State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. ....  
County of My place JUN 8 1922  
Primary Registration District No. ....  
City of Lewiston No. .... St.)

File No. 38616  
Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Stillborn Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

white

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

May 13<sup>th</sup> 1922  
(Month) (Day) (Year)

## 7. AGE

✓ Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

J. W. Green

## 11. BIRTHPLACE OF FATHER

(State or Country)

Texas

## 12. MAIDEN NAME OF MOTHER

Eula Halliwell  
Rocky Halls

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. F. Green

(Address)

Lewiston Idaho

## 15.

Filled June 9 1922 F. T. Harris M.D.  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 13<sup>th</sup> 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

May 13<sup>th</sup> 1922, to May 13<sup>th</sup> 1922

that I last saw him alive on Stillborn 19

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) O. B. Cepason M. D.

19..... (Address) Lewiston Id

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. .... mos. .... days. In the State..... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho

## DATE OF BURIAL

5/3 1922

## 20. UNDERTAKER

## ADDRESS

Lewiston Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

318-118-255-231  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Nezperce

City of Lewiston

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital St. Joseph's

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

File No. 102675

Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other?	{ and }	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>May-18-1922</u> (Month) (Day) (Year)
--------------------------	------------------------------	---------	--------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth. 1

Number of child of this mother now living, including present birth. \_\_\_\_\_

FATHER  
FULL NAME Basil Taylor  
RESIDENCE Lewiston, Idaho  
COLOR White AGE AT LAST BIRTHDAY 22 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Delivery man

MOTHER  
FULL MAIDEN NAME Ruth Blake  
RESIDENCE Lewiston, Idaho  
COLOR White AGE AT LAST BIRTHDAY 19 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ on the date above stated.

11:15 A. M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) O. E. Carraam  
Lewiston, Ida  
(Physician or midwife)

Give names added from a supplemental report.

June 7, 1922

F. T. Harris, M.D.

Registrar.

Address \_\_\_\_\_

Filed Jun 1922

Registrar.



## CERTIFICATE OF DEATH

38618

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Keyser*  
City of *Levinston*

Registration District No. ....

Primary Registration District No. ....

(No. ....) St. ....

File No. ....

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Stillborn Taylor*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*M**white*

(Write the word.)

## 6. DATE OF BIRTH

*May 25**1922*

(Month)

(Day)

(Year)

## 7. AGE

Yrs. ....

Mos. ....

ds. ....

IF LESS than 1 day  
how many ..... hrs.  
or ..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*Barclay Taylor*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Idaho*

## 12. MAIDEN NAME OF MOTHER

*Ruth Blake*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

## (Informant)

(Address)

*Barclay Taylor  
Levinston Idaho*

## 15.

Filed *June 9* 19 *22**F.T. Harris, M.D.*  
Local Registrar

## 16. DATE OF DEATH

*5**18**1922*

(Month)

(Day)

(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19.....

to

19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

*monition*

(Duration) Yrs. .... mos. .... ds. ....

Contributory (Secondary)

*Granular fat*

(Duration) yrs. .... mos. .... ds. ....

(Signed)

*Mc Carson*

M. D.

19.....

(Address)

*Levinston Id*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Levinston Idaho**5/25 1922*

## 20. UNDERTAKER

## ADDRESS

*Levinston Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH		RECEIVED		STATE OF IDAHO		Form V. S. No. 11-C-21m-4-5-17	
JUL 8 1912		BUREAU OF VITAL STATISTICS		S			
County of <i>Oneyda</i>		BUREAU OF VITAL STATISTICS		CERTIFICATE OF BIRTH			
City of <i>Malad</i>		Registration District No. <i>24</i>		File No. <i>102705</i>			
No. <i>386-112-036-799</i>		Primary Registration District No. <i>2069</i>		Registered No. <i>100</i>			
Hospital		FULL NAME OF CHILD <i>Lied unnamed</i>					
Sex of Child <i>Male</i>		Twin Triplet or other? <i>No</i>		and in order of birth <i>1</i>		Legitimate? <i>Yes</i>	
Date of Birth <i>6 12 1912</i>		(Month) (Day) (Year)					
FULL NAME <i>Le Roy Thomas</i>		FATHER		FULL MAIDEN NAME <i>Mattie E. Price</i>		MOTHER	
RESIDENCE <i>Malad</i>				RESIDENCE <i>Malad</i>			
COLOR <i>White</i>		AGE AT LAST BIRTHDAY <i>23</i>		COLOR <i>White</i>		AGE AT LAST BIRTHDAY <i>23</i>	
(Years)				(Years)			
BIRTHPLACE <i>Malad</i>				BIRTHPLACE <i>Malad</i>			
OCCUPATION <i>Common Laborer</i>				OCCUPATION <i>Housewife</i>			
Number of child of this mother, including present birth <i>1</i>		Number of children of this mother now living, including present birth <i>0</i>					
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE							
I hereby certify that I attended the birth of this child, who was <i>Stillborn</i> at <i>5:30 P.</i> on the date above stated.							
*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.							
(Signature) <i>J. F. Alton</i>							
(Physician or Midwife)							
Given names added from a supplemental report.							
Address <i>Malad</i>							
Filed <i>July 6 1912</i>							
Registrar <i>H. M. M. M.</i>							

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vi

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11



PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. & No. 11-0-22a-24-17

S

County of *Oneida*

JUL 8 1922

CERTIFICATE OF BIRTH

City of *Malad*  
No. *819-117-036-593*  
St.

BUREAU OF VITAL  
STATISTICS  
Registration District No.

*24*

File No. *102708*

Primary Registration District No. *2064*

Registered No. *103*

Hospital

FULL NAME OF CHILD

*Lied Lunn*

Sex of Child <i>Male</i>	Twin Triplet or other? <i>No</i>	and Number in order of birth <i>1</i>	Legitimate? <i>Yes</i>	Date of Birth <i>June 17</i>
(To be answered only in event of plural births)				(Month) (Day) (Year)

FATHER  
FULL NAME *Edgar J. Jackson*  
RESIDENCE *Malad*  
COLOR *White* AGE AT LAST BIRTHDAY *29* (Years)  
BIRTHPLACE *Utah*  
OCCUPATION *Farming*

MOTHER  
FULL MAIDEN NAME *Mary Nicholas*  
RESIDENCE *Malad*  
COLOR *White* AGE AT LAST BIRTHDAY *26* (Years)  
BIRTHPLACE *Malad*  
OCCUPATION *Housewife*

Number of child of this mother, including present birth *1* Number of children of this mother now living, including present birth *0*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was *Delborn* *29* M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *J. H. Hutton*  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

19

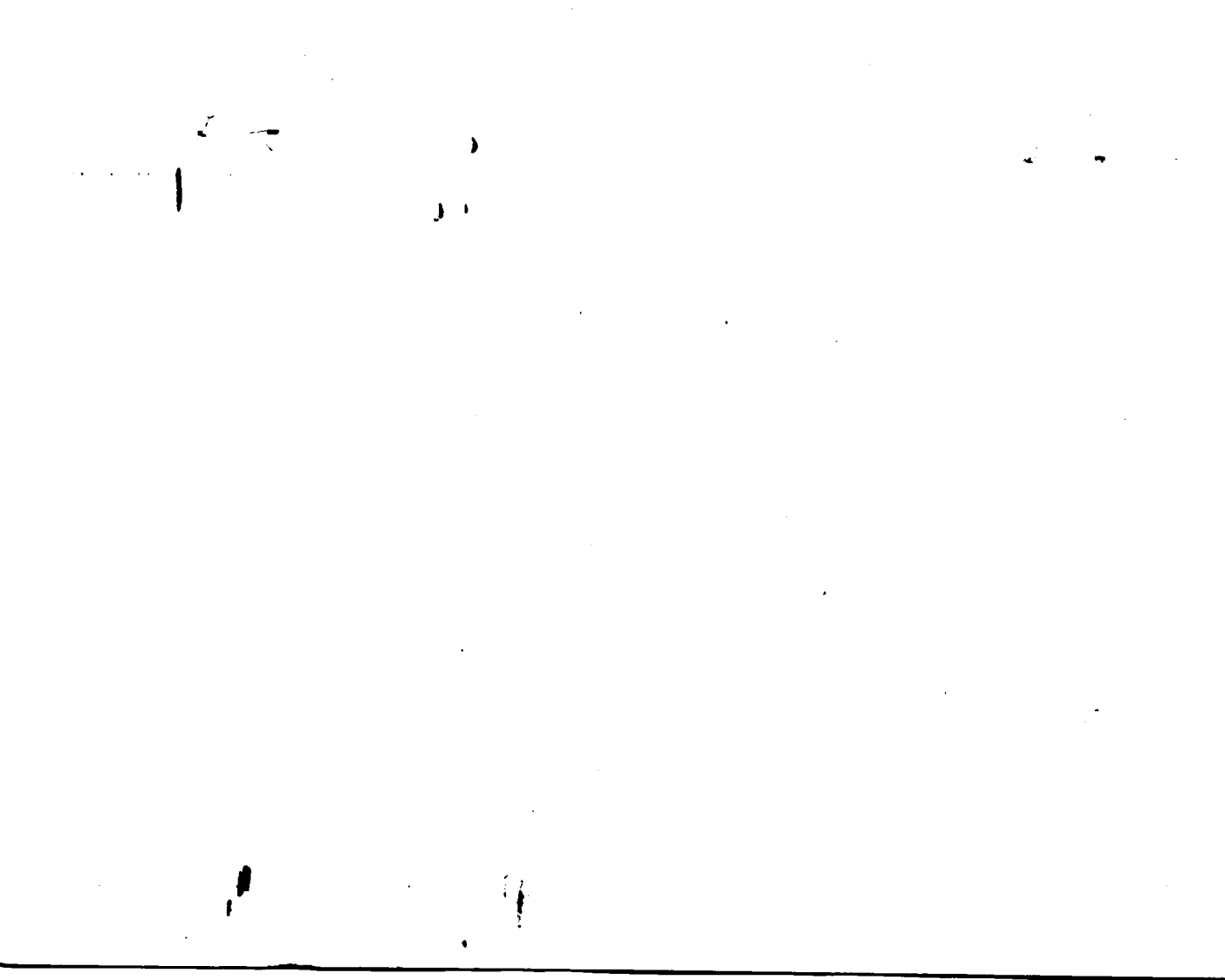
Address *Malad*

19

Filed *July 6 1922*

Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH  
County of *Conida*  
City of *Malad*  
Registration District No. *16*  
Primary Registration District No. *2099*  
(No. *16* St.)

File No. *38528*  
Registered No. *28*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *No Name*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Child*  
(Write the word.)

16. DATE OF DEATH *June 17 1922*  
(Month) (Day) (Year)

6. DATE OF BIRTH *June 17 1922*  
(Month) (Day) (Year)

7. AGE *Child born*  
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH\* was as follows:

8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

*Child born died in utero*  
(Duration) Yrs. mos. ds.

9. BIRTHPLACE *Malad Idaho*  
(State or Country)

Contributory (Secondary) (Duration) yrs. mos. ds.

10. NAME OF FATHER *Edgar J. Hansen*

(Signed) *J. F. Altman* M. D.  
19 (Address) *Malad Idaho*

11. BIRTHPLACE OF FATHER *Utah*  
(State or Country)

12. MAIDEN NAME OF MOTHER *Mary Nicholas*

13. BIRTHPLACE OF MOTHER *Idaho*  
(State or Country)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Edgar Hansen*  
(Address) *Malad Idaho*

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

15. Filed *July 6 1922*  
Local Registrar

19. PLACE OF BURIAL OR REMOVAL *Malad Idaho* DATE OF BURIAL *July 1 1922*

20. UNDERTAKER *J. Jay Benson* ADDRESS *Malad Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

295-111-038-249  
PLACE OF BIRTH

RECEIVED  
JUL 5 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

102723

County of Payette  
City of Payette  
No. Star Route St.

BUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 5

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2209

Registered No. 15

FULL NAME OF CHILD

Jack Bivans

(Certificate of no value without full name of child.)

Sex of Child <u>m</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>June 11</u> 192 <u>2</u> (Month) (Day) (Year)
-----------------------	--	------------------------	---

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. \_\_\_\_\_

FATHER  
FULL NAME Walker A. Bivans  
RESIDENCE Payette Ida RFD.  
COLOR m AGE AT LAST BIRTHDAY 25 (Years)  
BIRTHPLACE Ida.  
OCCUPATION farmer

MOTHER  
FULL MAIDEN NAME Marie Smith  
RESIDENCE with husband  
COLOR m AGE AT LAST BIRTHDAY 25 (Years)  
BIRTHPLACE Ore.  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 8:15 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Wm J. Drysdale MD

(Physician or midwife)

Give names added from a supplemental report.

Address Wm J. Drysdale Ida

Filed 6/12 1922 Wm J. Drysdale

Registrar.

Registrar.

DEPARTMENT OF PUBLIC HEALTH

GENERAL

OFFICE OF THE COMMISSIONER

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Payette, Ida.* File Number *102723*  
of { Street .....  
Birth { County *Payette* Registration Dist. No. ....  
Sex of Child *Male* Date of Birth *June 11* 192*2*.  
Father *Walker, Albert Bivens* Full Name Mother *Mrs. Marie Smith* Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Jack Bivens*  
Child's Name in Full

*Mrs. Walker A. Bivens*  
Signature of Father or Mother

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.



RECEIVED

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Payette*City of *Payette, Star Route*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Infant Bivans*State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *38624*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*M*

## 4. COLOR OR RACE

*W*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

*June 11 1922*  
(Month) (Day) (Year)

## 7. AGE

*Stillborn*IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*Wacker A. Bivans*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Ida*

## 12. MAIDEN NAME OF MOTHER

*Marie Smith*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Ida*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Wacker A. Bivans*

(Address)

*Payette, Ida Star Route*Filed *6/12**1922**W. J. Drysdale*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*June 11 1922*  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from  
*at birth* *10 4* to *19*that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ *19*  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

*Preecl Presentation -  
Asphyxia from prolonged  
labor*

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *W. J. Drysdale* M. D.*6/11 1922* (Address) *W. J. Drysdale*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Payette*

## DATE OF BURIAL

*6/12 1922*

## 20. UNDERTAKER

*Father & Child*

## ADDRESS

*Payette, Ida**Star Route*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

231-130-039-8 RECEIVED

PLACE OF BIRTH

JUN 22 1922

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of PowerCity of American FallsRegistration District No. 25File No. 102762

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2072Registered No. 397

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Not Named

Sex of Child <u>Male</u>	Twin <u>Yes</u> Triplet <u>No</u> or other? <u>No</u>	and {	Number in order of birth <u>13</u>	Legiti mate? <u>Yes</u>	Date of Birth <u>April 30 1922</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

FULL NAME Mark Elmer Stanger

RESIDENCE

American FallsCOLOR WhiteAGE AT LAST BIRTHDAY 37  
(Years)BIRTHPLACE UtahOCCUPATION FarmerFULL MAIDEN NAME Mable Harmsen

RESIDENCE

American FallsCOLOR WhiteAGE AT LAST BIRTHDAY 33  
(Years)BIRTHPLACE IdahoOCCUPATION Housewife

Number of child of this mother, including present birth <u>13</u>	Number of children of this mother now living, including present birth <u>4</u>
---	--

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 99 M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) V. G. Logan

(Physician or midwife)

Given names added from a supplemental report.

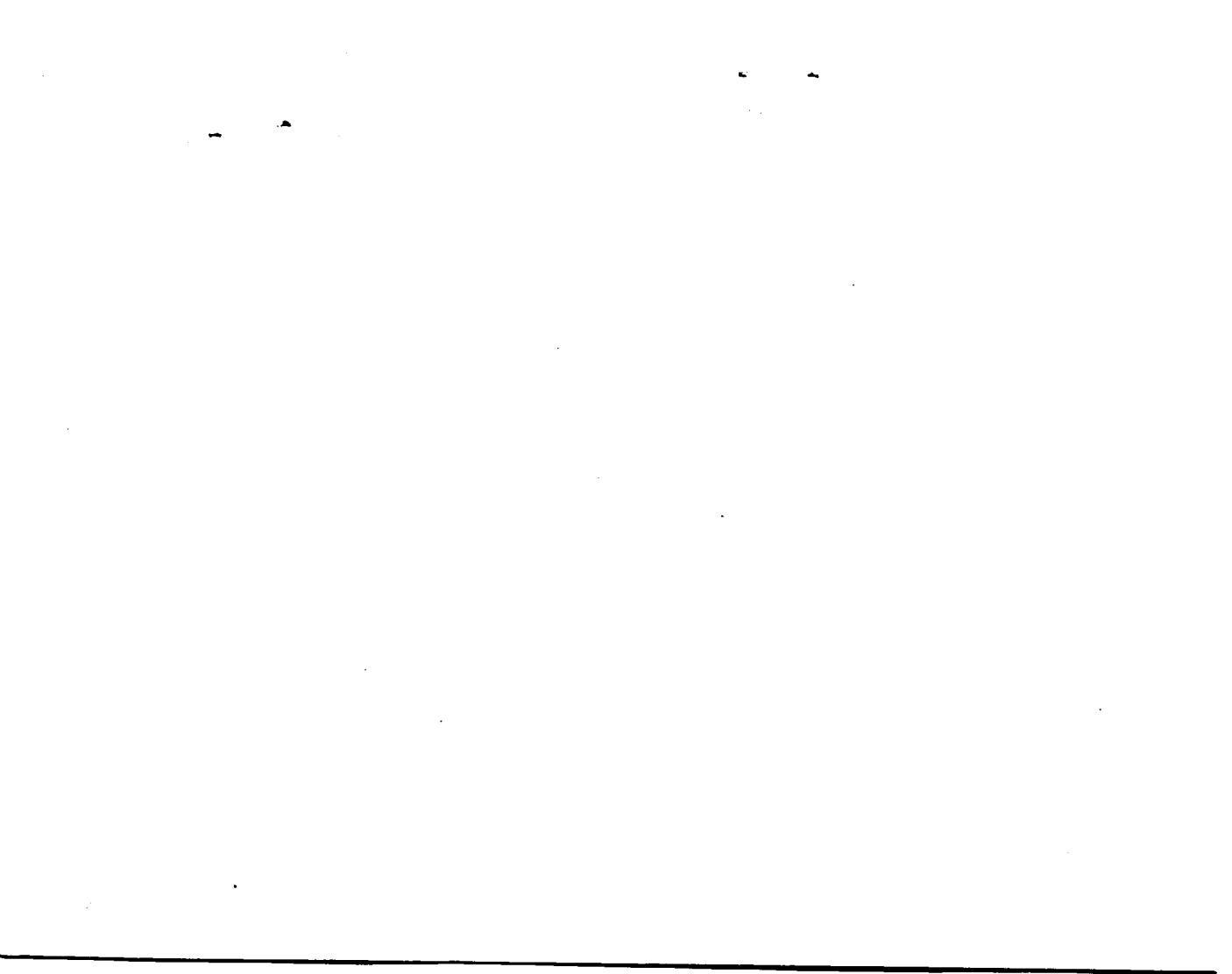
Address American FallsFiled 6-8

1922

R. L. North

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

## CERTIFICATE OF DEATH

38634 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County *Power*City of *American Falls*Registration District No. *25*Primary Registration District No. *2072*File No. *4*Registered No. *259*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*not named*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Male*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*Single*  
(Write the word.)

6. DATE OF BIRTH

*April 30 1922*  
(Month) (Day) (Year)

7. AGE

*— yrs. — mos. — ds.*IF LESS than 1 day  
how many . . . hrs. or  
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)*At home*

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*Marit Elmer Stanger*

11. BIRTHPLACE OF FATHER

(State or Country)

*Utah*

12. MAIDEN NAME OF MOTHER

*Mable Harmon*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mable Stanger*

(Address)

*American Falls, Ida*

15.

Filed

*6-8*19*22**R. L. Roth*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*April 30 1922*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*April 30 1922 to April 30 1922*  
that I last saw him alive on *April 30 1922*and that death occurred on the date stated above, at *9 AM*

The CAUSE OF DEATH\* was as follows

*Premature birth (still born)  
6 1/2 months of intra gestation*  
(Duration) yrs. mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death . . . yrs. . . mos. . . days. In the State . . . yrs. . . mos. . . days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of

City of

No.

Hospital

FULL NAME OF CHILD

BUREAU OF VITAL STATISTICS

Registration District No.

CERTIFICATE OF BIRTH

S 102804

File No.

Primary Registration District No.

Registered No.

Sex of  
ChildTwin  
Triplet  
or other?and { Number  
in order  
of birth

3

(To be answered only in event of plural births)

Legiti-  
mate?

yes

Date of  
Birth

4

26

1912

(Month) (Day) (Year)

FULL  
NAME

FATHER

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth. Number of children of this mother now living, including present birth.

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was ..... at ..... M.  
on the date above stated. (Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc., should  
make this return. A stillborn child is one that  
neither breathes nor shows other evidence of life  
after birth.

(Signature)

Given names added from a supplemental report.

Address

Filed

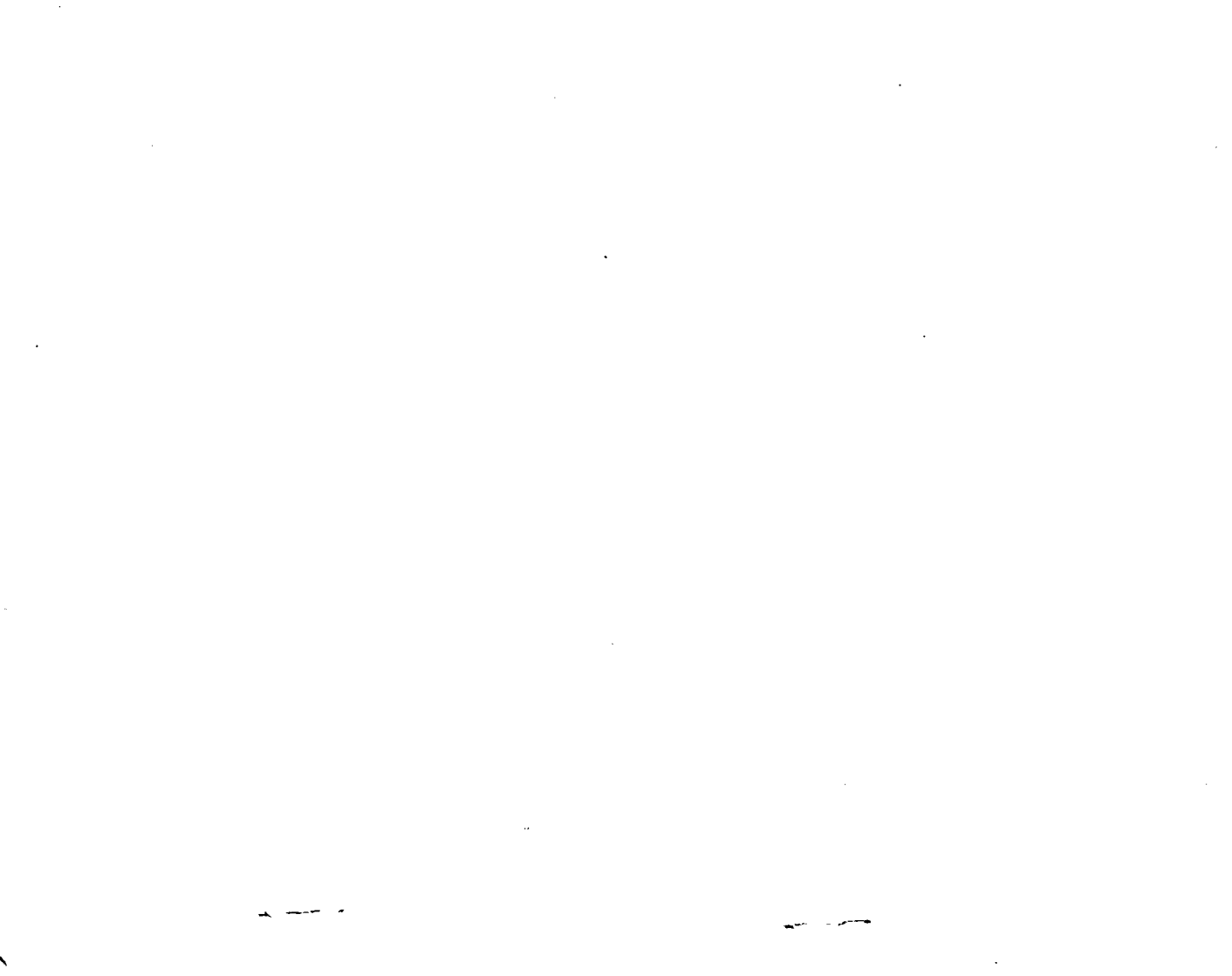
Registrar

Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.





363-219-042-796

Form V. S. No. 11-C--25m-7-21-19

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

County of Swain FallsCity of Hallistown R.F.D.Registration District No. 37File No. 102854No. 1 St. ✓Primary Registration District No. 2083 Registered No. \_\_\_\_\_Hospital ✓FULL NAME OF CHILD Cole-

Sex of Child <u>F.</u>	Twin <u>✓</u> Triplet <u>✓</u> or other? <u>✓</u> (To be answered only in event of plural births)	and <u>✓</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of Birth <u>June 19<sup>th</sup> 1922</u> (Month) (Day) (Year)
------------------------	--	--------------	-----------------------------------	------------------------	--

FULL NAME <u>Geo. R. Cole</u>	FATHER
RESIDENCE <u>Hallistown R.F.D.</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Lucasville Mo.</u>	
OCCUPATION <u>Auto Repair</u>	

FULL MAIDEN NAME <u>Helen Brown</u>	MOTHER
RESIDENCE <u>Hallistown R.F.D.</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Gainesville Mo.</u>	
OCCUPATION <u>Wife</u>	

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

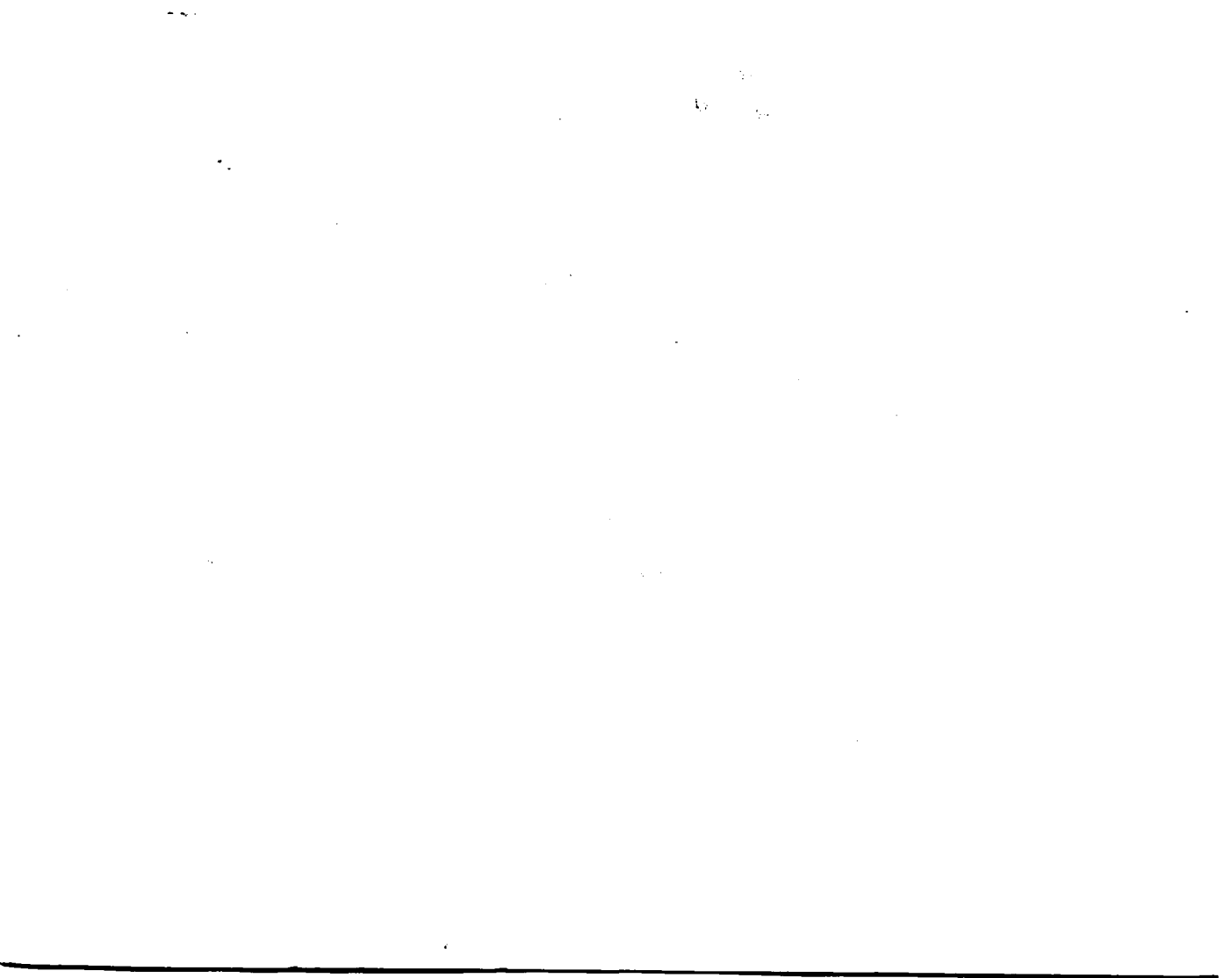
I hereby certify that I attended the birth of this child, who was Still born, at 12 Noon on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. H. Anderson  
(Physician or midwife)

Given names added from a supplemental report.

Address Swain Falls Dam  
Filed 6, 20 1922 John F. Connelley  
Registrar



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

413-122-042-291D

PLACE OF BIRTH

RECEIVED  
JUL 1 1922

Form V. S. No. 11-C-25m-7-21-19

County of Twin Falls STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

City of Twin Falls BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

102857

Registration District No. 37 File No. 102857  
No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital Co. Hospital Primary Registration District No. 1085 Registered No. \_\_\_\_\_

FULL NAME OF CHILD Baby Malmgren

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legit mate? <u>yes</u>	Date of Birth <u>May 22</u> 19 <u>22</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	---------------------------	---

FATHER  
FULL NAME E. H. Malmgren  
RESIDENCE Amsterdam  
COLOR white AGE AT LAST BIRTHDAY 23 (Years)  
BIRTHPLACE Utah  
OCCUPATION farmer

MOTHER  
FULL MAIDEN NAME Edith Grant  
RESIDENCE Amsterdam  
COLOR white AGE AT LAST BIRTHDAY 18 (Years)  
BIRTHPLACE Utah  
OCCUPATION housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 6 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. J. Gol, M.D.  
(Physician or midwife)

Given names added from a supplemental report.

Address Twin Falls  
Filed June 9-22 19\_\_\_\_  
Registrar John F. Loughlin

Registrar

СРАДНИК Н. А. П.

ПРАВАЯ СТОРОНА

С. 1

**STATE OF IDAHO**  
**DEPARTMENT OF PUBLIC WELFARE**

JUL 13 1922  
Boise, Idaho, .....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

---

Place of Birth	{ City .....	File Number .....102857.....
	{ Street .....	Registration Dist. No. ....
	{ County .....	
Sex of Child.....Male.....		Date of Birth .....192....
Father .....	Full Name	Mother ..... Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

.....  
Child's Name in Full

.....  
Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No. 37

Primary Registration District No. 1085

(No. County Hospital

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 38556  
Registered No.

If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

2. FULL NAME

Baby Malmgren

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

Male

White

Single

6. DATE OF BIRTH

May 22 1922

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

8. OCCUPATION

(a) Trade, profession or  
particular kind of work.  
(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF  
FATHER

Ed Malmgren

11. BIRTHPLACE  
OF FATHER

(State or Country)

Utah.

12. MAIDEN NAME  
OF MOTHER

Edith Grant

13. BIRTHPLACE  
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Malmgren

(Address)

Amesbury

15.

Filed June 9 1922

John Houghlin

Local Registrar

16. DATE OF DEATH

May 22 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from  
May 22 1922 to May 22 1922  
that I last saw him alive on May 22 1922  
and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH\* was as follows:

Malposition of baby at  
delivery

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Joseph Dugal

M. D.

19

(Address)

Jwin Falls

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted  
if not at place of death?

Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Levan Utah

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

## PLACE OF BIRTH

685-119-042-394

## STATE OF IDAHO

## DEPARTMENT OF PUBLIC WELFARE

## BUREAU OF VITAL STATISTICS

S

## CERTIFICATE OF BIRTH

102873

County of Twin FallsCity of Kimberly,No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 36 File No. \_\_\_\_\_Hospital home Primary Registration District No. \_\_\_\_\_ Registered No. 23FULL NAME OF CHILD No name

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	<u>Twin</u> Triplet or other? { and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>May 19</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? 00Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 0

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Byron R. Wheeler</u>	<u>Kimberly, Idaho</u>	<u>Opal Georgia Trueblood</u>	<u>Kimberly, Idaho</u>
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Utah</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>farmer</u>		OCCUPATION <u>Hw.</u>	

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 5:30 A M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. Davisphysician

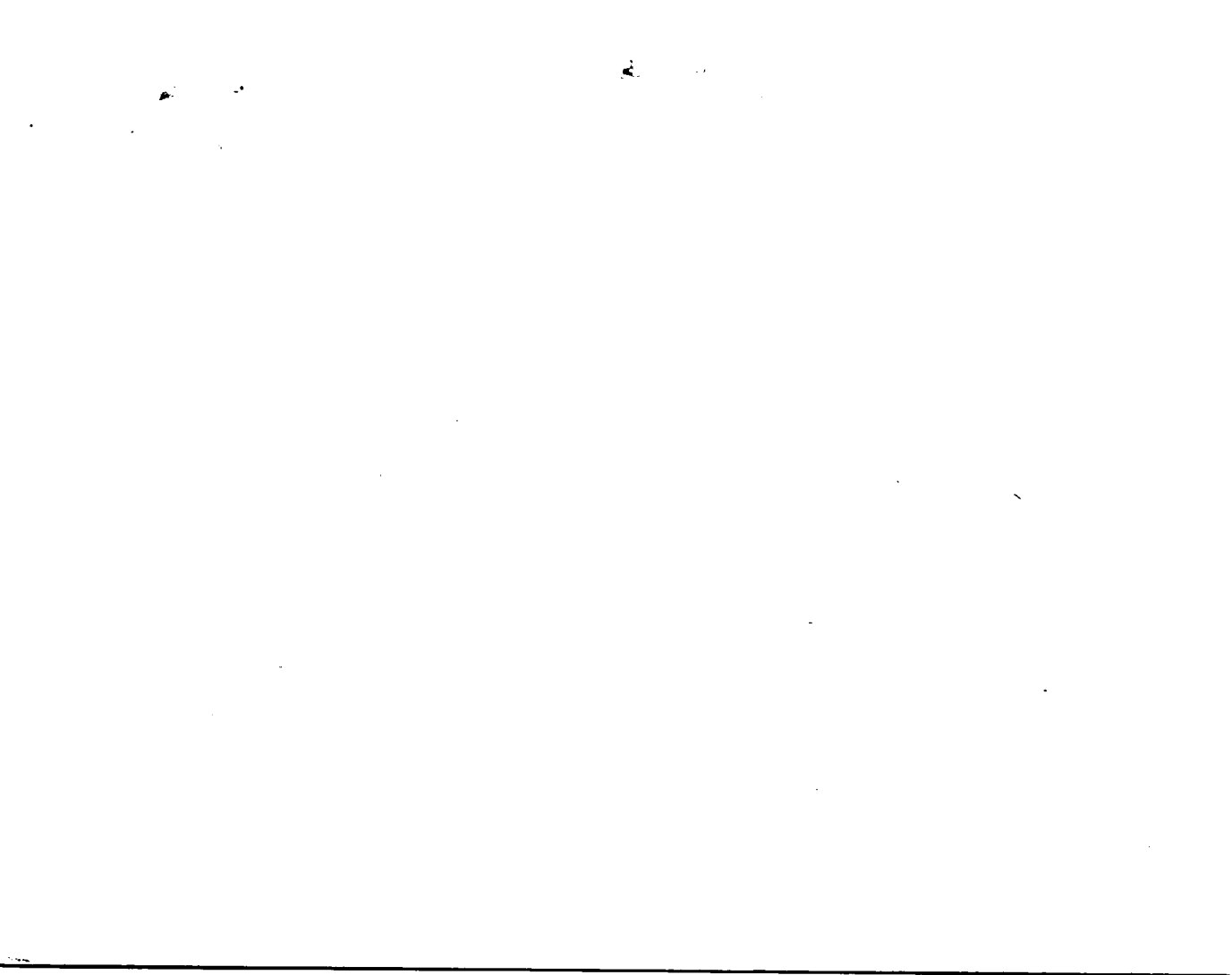
(Physician or midwife)

Give names added from a supplemental report.

Address Kimberly, IdahoFiled May 29, 1922

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED  
JUN 2 1922  
CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH Register District No. 36  
County of Twin Falls Primary Registration District No. \_\_\_\_\_  
City of Kimberly, Idaho (No. \_\_\_\_\_, St.) \_\_\_\_\_

File No. 38655

Registered No. 1896

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No Name Wheeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. X (Write the word.)

6. DATE OF BIRTH May, 19, 1922  
(Month) (Day) (Year)

7. AGE stillborn IF LESS than 1 day how many hrs. or mins. 0  
yrs. mos. ds.

8. OCCUPATION  
(a) Trade, profession or particular kind of work 0  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9. BIRTHPLACE  
(State or Country) Kimberly, Idaho

10. NAME OF FATHER Byron R. Wheeler

11. BIRTHPLACE OF FATHER Utah  
(State or Country)

12. MAIDEN NAME OF MOTHER Opal Georgia Trueblood

13. BIRTHPLACE OF MOTHER Idaho  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Byron R. Wheeler  
(Address) Kimberly, Idaho

15. Filed May 20, 1922 191 1922  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 19, 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 0 191, to 0 191, that I last saw h. alive on 0 191, and that death occurred on the date stated above, at 0 M. The CAUSE OF DEATH\* was as follows:

Stillbirth at about 6 months

(Duration) yrs. mos. ds. 0  
Contributory not known  
(Secondary)

(Duration) yrs. mos. ds. 0  
(Signed) M. D. Davis M. D.  
May 20, 1922 Address) Kimberly, Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL 0 DATE OF BURIAL May 19, 1922

20. UNDERTAKER 0 ADDRESS \_\_\_\_\_

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

City of BUREAU Registration District No. 37 File No. 102896  
 No. \_\_\_\_\_ St. \_\_\_\_\_  
 Hospital Co. General Primary Registration District No. 1085 Registered No. \_\_\_\_\_  
 FULL NAME OF CHILD \_\_\_\_\_

Sex of Child FM Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth 1 Legitimate? yes Date of Birth 6 2 1922  
 (To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
 FULL NAME C. H. Heath  
 RESIDENCE Trin Falls  
 COLOR W AGE AT LAST BIRTHDAY 33  
 (Years)  
 BIRTHPLACE Albion, Idaho  
 OCCUPATION Merchant

MOTHER  
 FULL MAIDEN NAME Alice Hubbard  
 RESIDENCE Trin Falls  
 COLOR white AGE AT LAST BIRTHDAY 37  
 (Years)  
 BIRTHPLACE Willard Utah  
 OCCUPATION Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 7<sup>00</sup> P. M.  
 on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. J. Milford  
Physician  
 (Physician or midwife)

Given names added from a supplemental report.

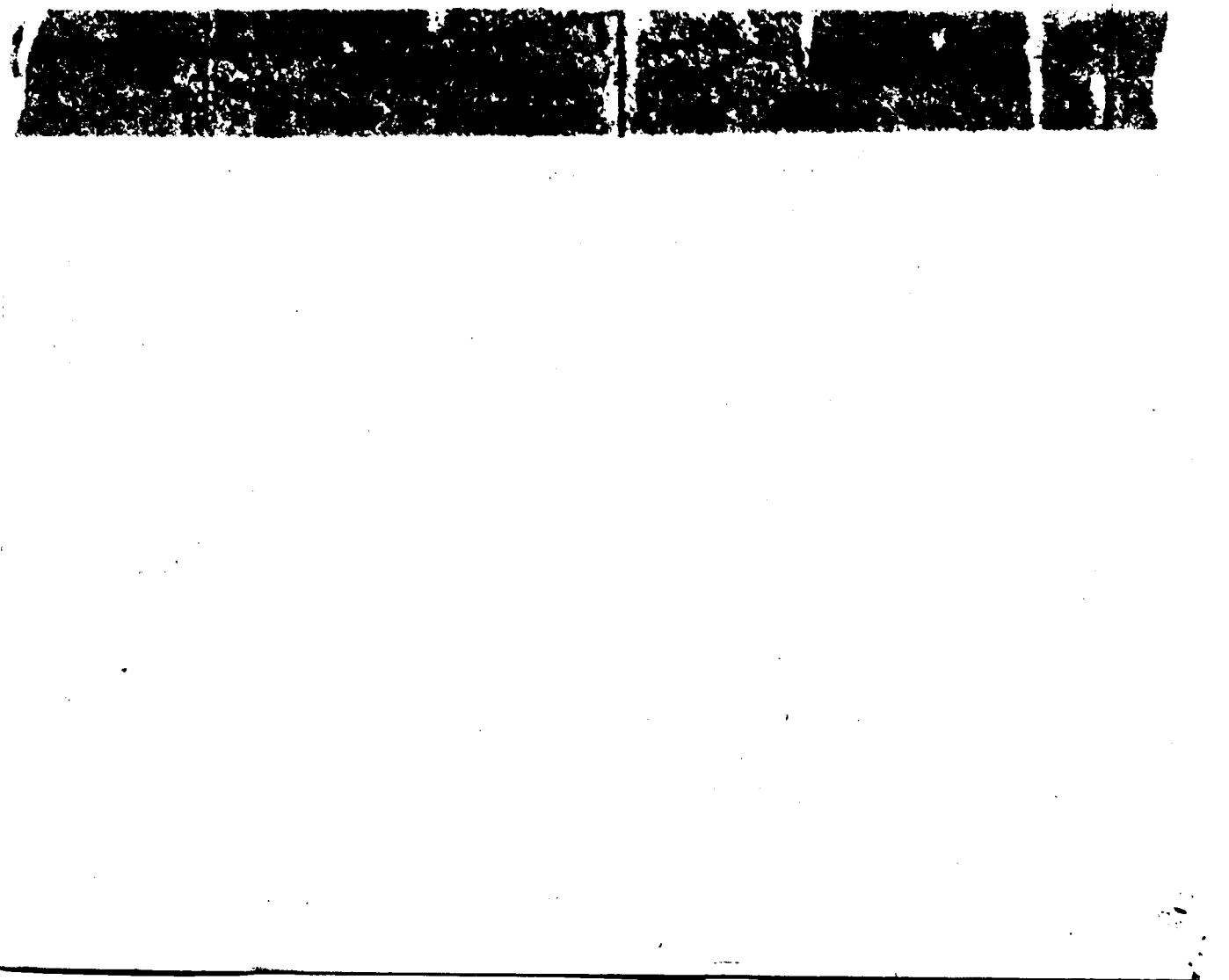
19

Address

Filed June 9 1922

Registrar

Registrar



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Twin Falls*  
 City of *Twin Falls*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *34*Primary Registration District No. *1080*(No. *1080* St.)

## 2. FULL NAME

*Ida Hubbard*

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. *38671*Registered No. *38671*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Female*

## 4. COLOR OR RACE

*W*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Single*  
(Write the word.)

## 6. DATE OF BIRTH

*June 2 1922*  
 (Month) (Day) (Year)

## 7. AGE

*Stillborn*  
Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

*Twin Falls Ida*  
(State or Country)

## 10. NAME OF FATHER

*C. N. Leavitt*

## 11. BIRTHPLACE OF FATHER

*Albion Ida*  
(State or Country)

## 12. MAIDEN NAME OF MOTHER

*Ida Ellice Hubbard*

## 13. BIRTHPLACE OF MOTHER

*Willard Utah*  
(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*C. N. Leavitt*  
(Address) *Twin Falls Ida*

## 15.

Filed *June 14 1922* *John F. Boughton*  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

*1896*

## 16. DATE OF DEATH

*June 2 1922*  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to .....19.....  
 that I last saw h..... alive on .....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*

.....(Duration).....Yrs.....mos.....ds.

Contributory.....  
 (Secondary)

.....(Duration).....Yrs.....mos.....ds.

(Signed)

*C. N. Leavitt* M. D.  
*6-2-1922* (Address) *Twin Falls Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days. In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Elba Ida*

## DATE OF BURIAL

*June 4 1922*

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbohc acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 215-122-042-7925 BUREAU OF VITAL STATISTICS  
County Winn Falls JUN 22 1922  
City of Buhl BUREAU OF VITAL STATISTICS  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 37 File No. 102916  
Hospital Winn Falls Co. Primary Registration District No. 1085 Registered No. \_\_\_\_\_  
FULL NAME OF CHILD Stillborn  
(Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twin Triplet or other? <u>✓</u> (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>5-12</u> (Month) (Day) (Year) <u>1921</u>
What bacterioidal solution was used in eyes? _____				
Number of child of this mother, including present birth... <u>1</u> Number of child of this mother now living, including present birth... <u>0</u>				
FATHER FULL NAME <u>B. L. Kausner</u>			MOTHER FULL MAIDEN NAME <u>Klausen Prosser</u>	
RESIDENCE <u>Buhl</u>			RESIDENCE <u>same</u>	
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)		COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>N. W.</u>			BIRTHPLACE <u>Ida</u>	
OCCUPATION <u>Farmer</u>			OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*  
I hereby certify that I attended the birth of this child, who was Still Born 11:30 a.m.  
(Born alive or stillborn)  
on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. H. Murphy  
M. W.  
(Physician or midwife)  
Address Buhl Ida  
Filed June 9 192 2 John Houghlin Registrar.

Registrar.

STANDARD

BIRTH

SEVERAL

PLEASE FILE

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH *Twinn Falls* Registration District No. *37*  
 County of *Buhl* Primary Registration District No. *208738253*  
 City of *Buhl* (No. \_\_\_\_\_) St. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 If death occurs away from usual residence, give facts called for under special information. *None (Stillborn)* If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED  
 (Write the word.)

6. DATE OF BIRTH *May 22 1922*  
 (Month) (Day) (Year)

7. AGE \_\_\_\_\_ IF LESS than 1 day  
 Yrs. Mos. ds. how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed *5-23* 19*22*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*May 22 1922*  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date stated above, at \_\_\_\_\_ M.  
 The CAUSE OF DEATH\* was as follows:  
*still born*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*J. H. Murphy* M. D.  
 Address) *Buhl Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Buhl Ida* *5-23 1922*

## 20. UNDERTAKER

## ADDRESS

*L. Johnson* *Buhl*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name or gin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

685-123-001-493

PLACE OF BIRTH

RECEIVED

AUG 5 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Ada BUREAU OF VITAL STATISTICS  
City of Boise  
No. RJ # 4 St. Registration District No. 8 File No. 102970  
Hospital Primary Registration District No. 2008 Registered No. 46

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twins Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legiti- mate? <u>ye</u>	Date of birth. <u>7/23</u> 192 <u>2</u> (Month) (Day) (Year)
-----------------------	--	---------------------------------------	----------------------------	--

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 0

FULL NAME <u>NEWELL E. WHEELER</u>	FATHER	FULL MAIDEN NAME <u>ANNY MILLER</u>	MOTHER
RESIDENCE <u>Boise RJ # 4</u>		RESIDENCE <u>Boise RJ # 4</u>	
COLOR <u>Bl.</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>Bl.</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Mo</u>		BIRTHPLACE <u>Kansas</u>	
OCCUPATION <u>Rancher</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Fred A. Pittman

(Physician or midwife)

Give names added from a supplemental report.

Address Oakland Blk. Boise

Filed July 26 1922 R. H. Pratt

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

Registration District No. 8

County of Adair

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert N. Wheeler

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 38699

Registered No. 66

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M. White Single

6. DATE OF BIRTH

July 23 1922  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds. IF LESS than 1 day  
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Newel Wheeler

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Amy Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Krebs

(Address)

Boise Idaho

15.

Filed 19

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 23 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

7/23 1922 to 7/23 1922

that I last saw ~~her~~ alive on 7/23 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

asphyxia neonatorum  
neonatorum

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Breach delivery

(Duration) yrs. mos. ds.

(Signed)

J. A. Tuttle M. D.

7/23 1922

(Address)

Boise

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem.

July 24 1922

20. UNDERTAKER

ADDRESS

Hemmer &amp; Krebs

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



253-220-001-418  
PLACE OF BIRTHSTATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

## CERTIFICATE OF BIRTH

102992

County of Ada  
City of Meridian  
No. 11 Registration District No. 11 File No. 102992  
Hospital STATISTICS Primary Registration District No. 32  
Registered No. 32  
FULL NAME OF CHILD Pauline Keller  
(Certificate of no value without full name of child.)

Sex of Child female Twin Triplet or other? no and Number in order of birth 1 Legitimate? yes Date of birth 5 20 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 1% Sol. Silver Nitrate

Number of child of this mother, including present birth... 5 Number of children of this mother now living, including present birth... 4

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Monroe W. Keller</u>	<u>Meridian</u>	<u>Ida B. Mayes</u>	<u>Meridian</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Missouri</u>		BIRTHPLACE <u>Arkansas</u>	
OCCUPATION <u>farmer</u>		OCCUPATION <u>housewife</u>	

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 5:20 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. F. Meaf  
M. D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Meridian Idaho

Filed

7-2 1922

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

100

100

FORM V. S. No. 5-A-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **38725**  
Registered No. \_\_\_\_\_

1. PLACE OF DEATH **Idaho** JUL 12 1922  
County of **Ada** Registration District No. \_\_\_\_\_  
City of **Meridian** Primary Registration District No. \_\_\_\_\_  
State (No.) \_\_\_\_\_ St. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Pauline Keller**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Stillborn**

6. DATE OF BIRTH

**May 21 1922**  
(Month) (Day) (Year)

7. AGE

**Still Born**

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

**none**

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Meridian Idaho**

10. NAME OF FATHER

**Wm. W. Keller**

11. BIRTHPLACE OF FATHER

(State or Country) **Idaho**

12. MAIDEN NAME OF MOTHER

**Ida Mayes**

13. BIRTHPLACE OF MOTHER

(State or Country) **Arkansas**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**W. J. Mayes**

(Address)

**Meridian Idaho**

15.

Filed

**5-22 1922 J. H. Mayes**

Local Registrar

16. DATE OF DEATH

**May 21 1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 \_\_\_\_\_ to 19 \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on 19 \_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

**Stillborn**

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) **J. H. Mayes** M. D.**5-22-22** (Address) **Meridian**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

**Meridian Cemetery****May 22 1922**

20. UNDERTAKER

ADDRESS

**W. B. Shattuck Meridian Id**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## PLACE OF BIRTH

215-221-014-1165

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

County of CanyonRECEIVED  
JUL 12 1922City of Nampa

BUREAU OF VITAL STATISTICS

Registration District No. 7File No. 103086

No. \_\_\_\_\_

St. \_\_\_\_\_

Primary Registration District No. 2006

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD UnnamedSex of Child FTwin  
Triplet  
or other?  
(To be answered only in event of plural births)and (Number  
in order  
of birth)Legitimate? yesDate of Birth 6-7-22

(Month) (Day) (Year)

FULL NAME Loy Franklin Sandy

FATHER

FULL MAIDEN NAME Gertrude May Jones

MOTHER

RESIDENCE NampaRESIDENCE NampaCOLOR WhiteAGE AT LAST BIRTHDAY 31

(Years)

COLOR WhiteAGE AT LAST BIRTHDAY 31

(Years)

BIRTHPLACE MOBIRTHPLACE MOOCCUPATION RancherOCCUPATION HousewifeNumber of child of this mother, including present birth, 3 Number of children of this mother now living, including present birth, 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born at 9:15 A M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. R. Meredith D.D.

Given names added from a supplemental report. \_\_\_\_\_

19

Address \_\_\_\_\_

Filed July 5th 1922Pearle Dodds  
Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **38755**

1. PLACE OF DEATH.

Registered District No. **7**County of **Canyon**Primary Registration District No. **2006**City of **Julia**(No. **1137** St.)Registered No. **38755**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

**Infant Sarah**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

**F**

4. COLOR OR RACE

**White**

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

**6-21-22**  
(Month) (Day) (Year)

7. AGE

**Premature Stillborn**  
IF LESS than 1 day how many hrs. or mins.?  
yrs. mos. ds.

8. OCCUPATION

- (a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

**R.D. 2. Nampa**

10. NAME OF FATHER

**Loy Franklin Sandy**

11. BIRTHPLACE OF FATHER

(State or Country)

**Mo.**

12. MAIDEN NAME OF MOTHER

(State or Country)

**Estelle May Jones**

13. BIRTHPLACE OF MOTHER

(State or Country)

**Mo**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **E. R. Meredith D.D.**(Address) **Box 578 Nampa**

15.

Filed **July 5** 1922 **Pearle D. Davis**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

**6-21-1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw him alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

**Still born**  
**Intrauterine death no motion**  
**for a week**  
(Duration) yrs. mos. ds.  
Contributory (Secondary) **Distention & more**

(Signed) **E. R. Meredith D.D.** M. D.  
1922 (Address) **Box 578 - Nampa**

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. ... mos. ... days. In the State... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

**Intestate**

DATE OF BURIAL

191...

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

243-119-016-299  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

103126

County of Yazoo

City of Oakley

No. \_\_\_\_\_

Hospital \_\_\_\_\_

RECEIVED

JUL 18 1922

BUREAU OF VITAL STATISTICS

Registration District No. \_\_\_\_\_

CERTIFICATE OF BIRTH

120

File No. EX 11

Registration District No. 2199

Registered No. 86

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin <u>twins</u> Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth <u>2</u>	Legitimate? <u>yes</u>	Date of birth June 9 1922 (Month) (Day) (Year)
-----------------------------	--	-----	--	---------------------------	--

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth... 3 Number of child of this mother now living, including present birth... 1

FATHER  
FULL NAME J. H. Sutton  
RESIDENCE Oakley Idaho  
COLOR white  
AGE AT LAST BIRTHDAY 43 (Years)  
BIRTHPLACE Wah  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Irene Birch  
RESIDENCE Oakley Idaho  
COLOR white  
AGE AT LAST BIRTHDAY 43 (Years)  
BIRTHPLACE Wah  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

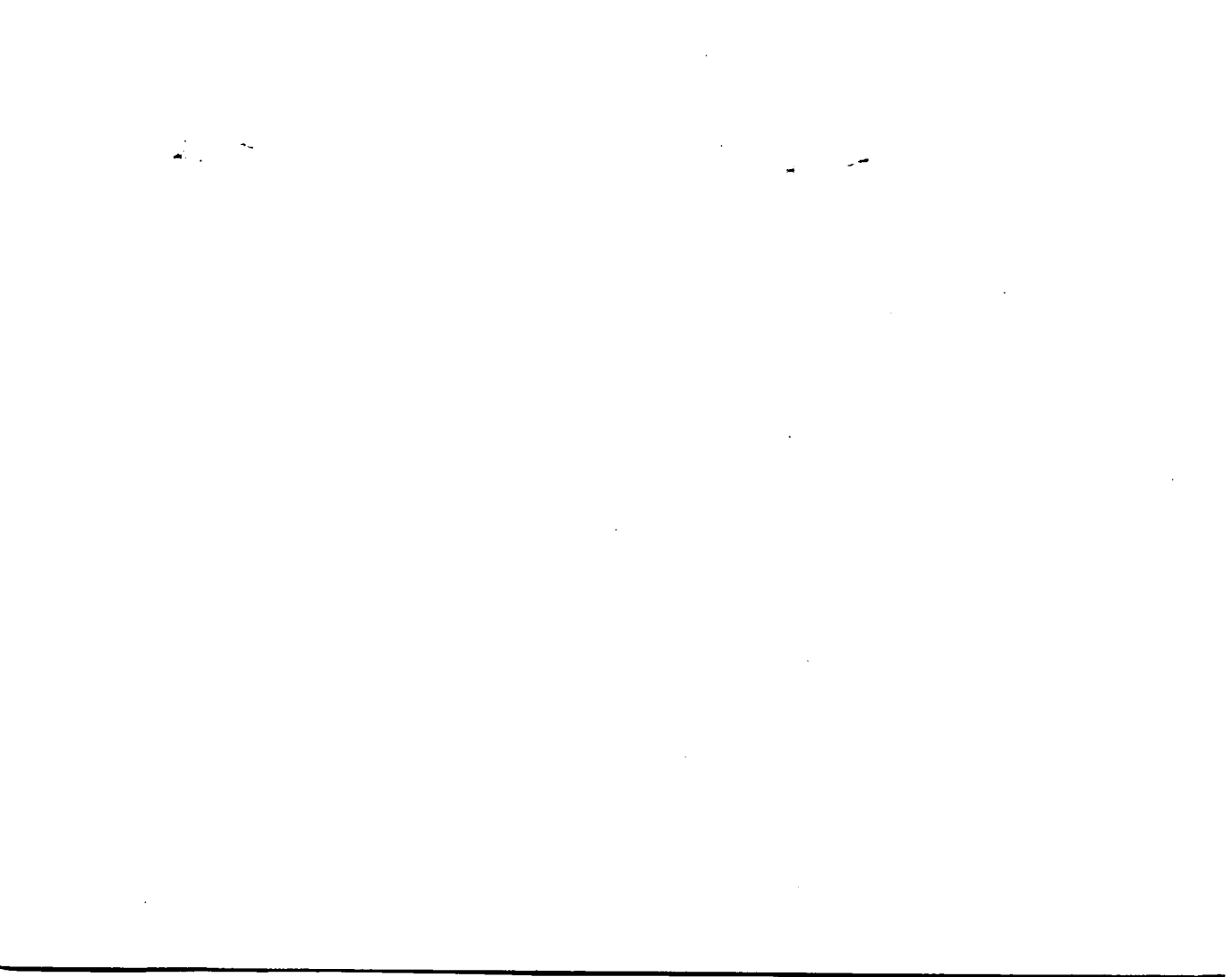
I hereby certify that I attended the birth of this child, who was stillborn 29 M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) A. H. Nelson  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Oakley Idaho  
Filed June 30 1922 A. H. Nelson  
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

38769 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH  
County of Cassia  
City of Blackfoot  
Registration District No. 120  
Primary Registration District No. 2199  
St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
JUL 13 1922  
BUREAU OF VITAL STATISTICS

File No. XV44  
Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John H. Sutton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ma 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single  
(Write the word.)

6. DATE OF BIRTH June 19 1922  
(Month) (Day) (Year)

7. AGE 1 Yrs. 0 Mos. 0 ds. 0 or 0 min.?  
IF LESS than 1 day how many hrs.

8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho  
(State or Country)

10. NAME OF FATHER J. H. Sutton

11. BIRTHPLACE OF FATHER Utah  
(State or Country)

12. MAIDEN NAME OF MOTHER Gene Birch

13. BIRTHPLACE OF MOTHER Utah  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J. H. Sutton  
(Address) Blackfoot, Idaho

15. Filled June 30 1922  
Local Registrar J. H. Sutton

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 19 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19  
that I last saw h. alive on 19  
and that death occurred on the date stated above, at M.  
The CAUSE OF DEATH\* was as follows:

(Duration) Yrs. mos. ds.  
Contributory (Secondary)  
(Duration) Yrs. mos. ds.  
(Signed) J. H. Sutton M. D.  
1922 (Address) Blackfoot, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death Yrs. mos. days. In the State Yrs. mos. days.  
Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Blackfoot, Idaho DATE OF BURIAL July 19 1922  
20. UNDERTAKER John H. Sutton ADDRESS Blackfoot, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

299-218-016-219  
PLACE OF BIRTH

DEPARTMENT OF HEALTH, BUREAU OF VITAL STATISTICS

S

County of Sassier  
 City of Burley  
 No. \_\_\_\_\_ St. \_\_\_\_\_  
 Hospital \_\_\_\_\_  
 Registration District No. 117 File No. 103145  
 Primary Registration District No. 2196 Registered No. 2312  
 FULL NAME OF CHILD Stillborn  
 (Certificate of no value without full name of child.)

Sex of Child <u>F</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { } Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>June 18</u> 192 <u>2</u> (Month) (Day) (Year)
-----------------------	---	-------------------------------------	------------------------	---

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth.....1..... Number of child of this mother now living, including present birth.....1.....

FULL NAME <u>F. L. Briggs</u>	FATHER	FULL MAIDEN NAME <u>Mabel Bailey</u>	MOTHER
RESIDENCE <u>Burley</u>		RESIDENCE <u>Burley</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>18</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>16</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Farming</u>		OCCUPATION <u>Idaho</u>	

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 A M.  
 on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Dr. J. C. Patterson  
 Physician  
 (Physician or midwife)  
 Address Burley Idaho  
 Filed June 27 1922 Dr. J. C. Patterson  
 Registrar.

Registrar.



PH  
24

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 38773  
Registered No. 6871

1. PLACE OF DEATH

Registration District No. 117  
County of Cassia  
Primary Registration District No. 2196  
City of Burley, Idaho

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Stielborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH June 18 1922 (Month) (Day) (Year)

7. AGE Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Burley, Idaho (State or Country)

10. NAME OF FATHER F. L. Briggs

11. BIRTHPLACE OF FATHER Idaho (State or Country)

12. MAIDEN NAME OF MOTHER Mabel Bailey

13. BIRTHPLACE OF MOTHER Utah (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) F. L. Briggs (Address) Burley, Idaho

15. Filed June 27 1922 J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 18 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw h. alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH\* was as follows: Stielborn

(Duration) Yrs. mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) J. S. Patterson M. D. 6/18 1922 (Address) Burley, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days. Where was disease contracted if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burley, Idaho DATE OF BURIAL 6/18 1922 20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

208-021-791  
PLACE OF BIRTH

RECEIVED  
AUG 5 1922  
BUREAU OF VITAL STATISTICS  
TAMPA

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

103182

County of Franklin  
City of Clifton  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 27 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2119 Registered No. 188  
FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>F</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth. <u>July 8</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? 1. 1/2 oz. no. 3

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FULL NAME <u>George Albert Bush</u>	FATHER	FULL MAIDEN NAME <u>Lillian Lucile Gray</u>	MOTHER
RESIDENCE <u>Clifton Idaho</u>		RESIDENCE <u>Clifton, Idaho</u>	
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)	COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Colo.</u>		BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 7:40 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

\_\_\_\_\_, 19\_\_\_\_

\_\_\_\_\_, Registrar.

(Signature)

Curtis Hand

(Physician or midwife)

Address

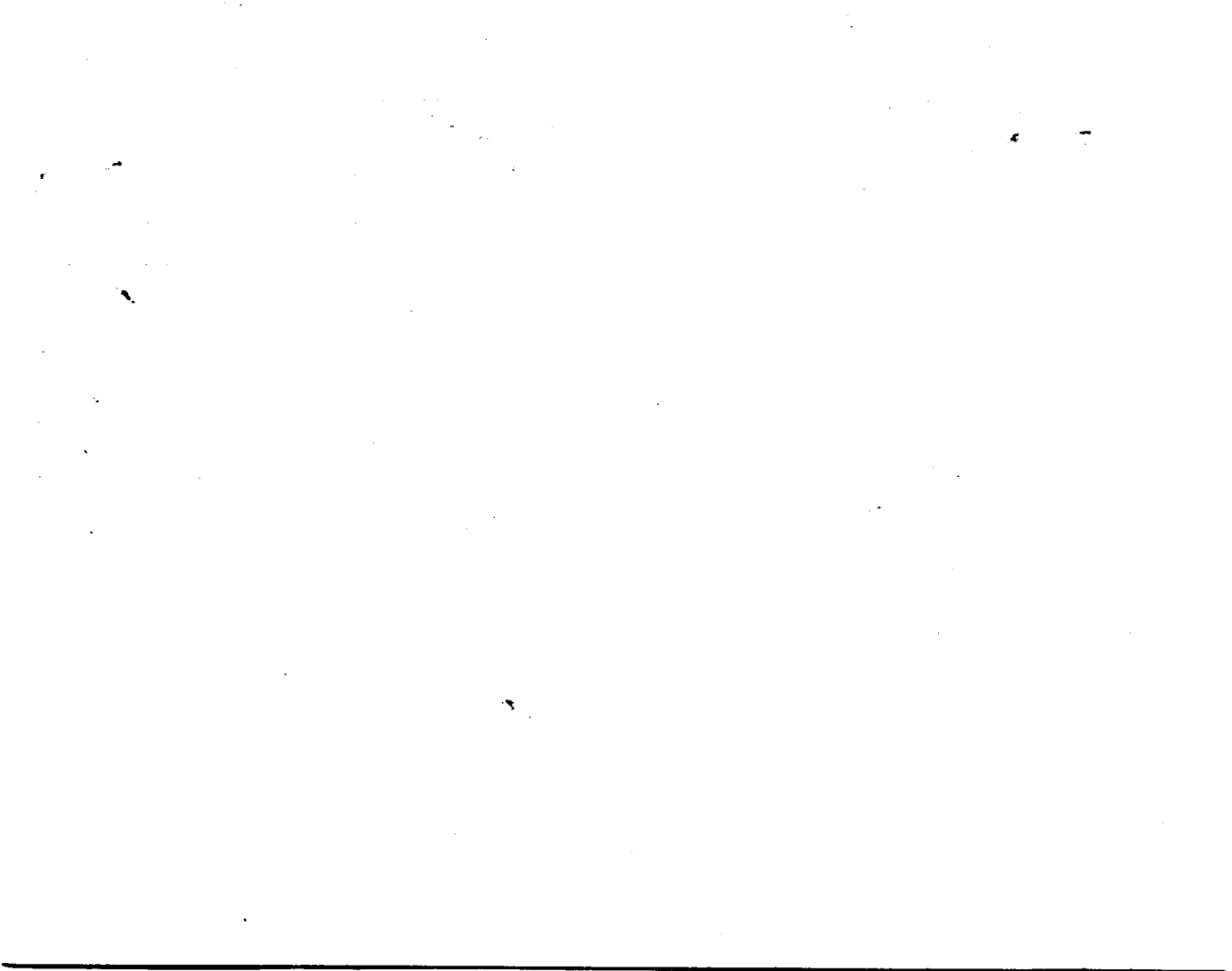
Preston, Idaho

Filed

Aug 2 1922

Mrs. Ida L. Lippert

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED  
AUG 5 1922  
BUREAU OF VITAL STATISTICS  
STATE OF IDAHO

1. PLACE OF DEATH

County of Franklin  
City of Clifton

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed - Stillson

CERTIFICATE OF DEATH

Registration District No. 27  
Registration District No. 2119 St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 38780

Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

6. DATE OF BIRTH

July (Month) 8 (Day) 1922 (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
how many 0 hrs.  
or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George Albert Bush

11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME OF MOTHER

Lillian Lucile Gray

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. A. Bush

(Address)

Clifton, Idaho

15.

Filed Aug 2 19 22 Mrs. Ida T. Tye  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 8 (Day) 19 22 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1922 to July 8 1922 that I last saw h.e.a. alive on Stillson 1922 and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH\* was as follows:

Tetraprosopus — an  
enophthalmus with boneless fingers  
also projection from mid line of forehead  
(Duration)        Yrs.        mos.        ds.

Contributory  
(Secondary)

(Duration)        yrs.        mos.        ds.  
(Signed) George A. Bush M. D.  
7/8 1922 (Address) Clifton, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death        yrs.        mos.        days. In the State        yrs.        mos.        days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clifton Idaho

DATE OF BURIAL

7-8-1922

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

249.2151027-799

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-8-15

County of JeromeCity of Eden

RECEIVED

JUN 2 1922

No. \_\_\_\_\_

Primary Registration District No. 2017

Registered No. \_\_\_\_\_

S

No. 103226

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and } Number in order of birth _____	Legitimate? <u>Yes</u>	Date of Birth <u>May 15</u> 19 <u>22</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	--

FATHER		MOTHER	
FULL NAME <u>James D. Burgoyne</u>	FULL MAIDEN NAME <u>Cora Price</u>	FULL NAME <u>Cora Price</u>	FULL MAIDEN NAME _____
RESIDENCE <u>Eden, Ida.</u>	RESIDENCE <u>Eden, Ida.</u>	RESIDENCE <u>Eden, Ida.</u>	RESIDENCE _____
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>	BIRTHPLACE _____
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Farmer</u>	OCCUPATION <u>Idler</u>	OCCUPATION _____

Number of child of this mother, including present birth. <u>7</u>	Number of children of this mother now living, including present birth. <u>6</u>
---	---

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE \*

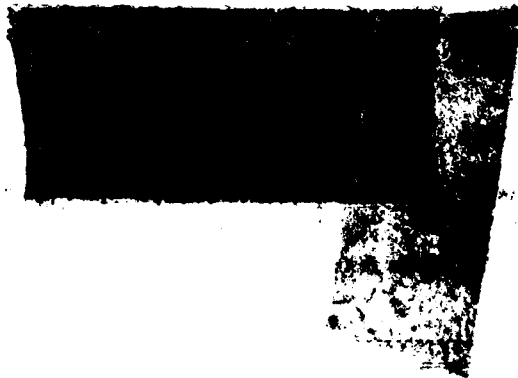
I hereby certify that I attended the birth of this child, who was stillborn at 29 M. on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. P. Scroggs M.D.

Given names added from a supplemental report.

Address Eden, Ida. (Physician or midwife)Filed June 12 1922 E. D. Piper M.D.



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

413-2091029239

PLACE OF BIRTH

County of

City of

No.

St.

Hospital

FULL NAME OF CHILD

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS—  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C--25m-7-21-19

S 103239

Registration District No.

File No.

Primary Registration District No.

Registered No.

Sex of Child

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti  
mate?

Date of  
Birth

(Month)

(Day)

(Year)

FULL  
NAME

FATHER

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth.

Number of children of this mother now living, including present birth.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was

(Born alive or stillborn)

at

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report

Address

Filed

Registrar

Registrar

10/10/12  
10/10/12

10/10/12  
10/10/12



FORM V. S. No. 5-25 M. 1-19.

RECEIVED

## CERTIFICATE OF DEATH

38784 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.)

(St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

## 4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word.)

## 6. DATE OF BIRTH

## 7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work.
- (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15. Filled

Local Registrar

## 16. DATE OF DEATH

## 17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

mother falling & injuring the fetus about 2 weeks ago. Causing a premature birth.

(Duration) yrs. mos. ds.

Contributory (Secondary) (7 1/2 mo. gestation)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

Died July 9.  
Gm 5/13/97

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

766-230-030-355  
PLACE OF BIRTH

County of Lemhi

City of Salmon

No. .... St.

Hospital .....

FULL NAME OF CHILD .....

RECEIVED  
JUL 15 1922

Registration District No. 41

Primary Registration District No. 2116

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25-1-17

103250

File No. ....

Registered No. ....

Sex of Child <u>female</u>	Twin Triplet or other? <u>and</u> Number in order of birth <u>1</u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of Birth <u>July 30<sup>th</sup> 1922</u> (Month) (Day) (Year)
----------------------------	--	------------------------	--

FULL NAME <u>Deyan Goodale</u>	FATHER
RESIDENCE <u>Salmon</u>	
COLOR <u>wh</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Ida</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Crystal Goodale</u>	MOTHER
RESIDENCE <u>Salmon</u>	
COLOR <u>wh</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Ida</u>	
OCCUPATION <u>Hom</u>	

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born dead 5 mo fetus at 6 P on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. Wright  
.....  
(Physician or midwife)

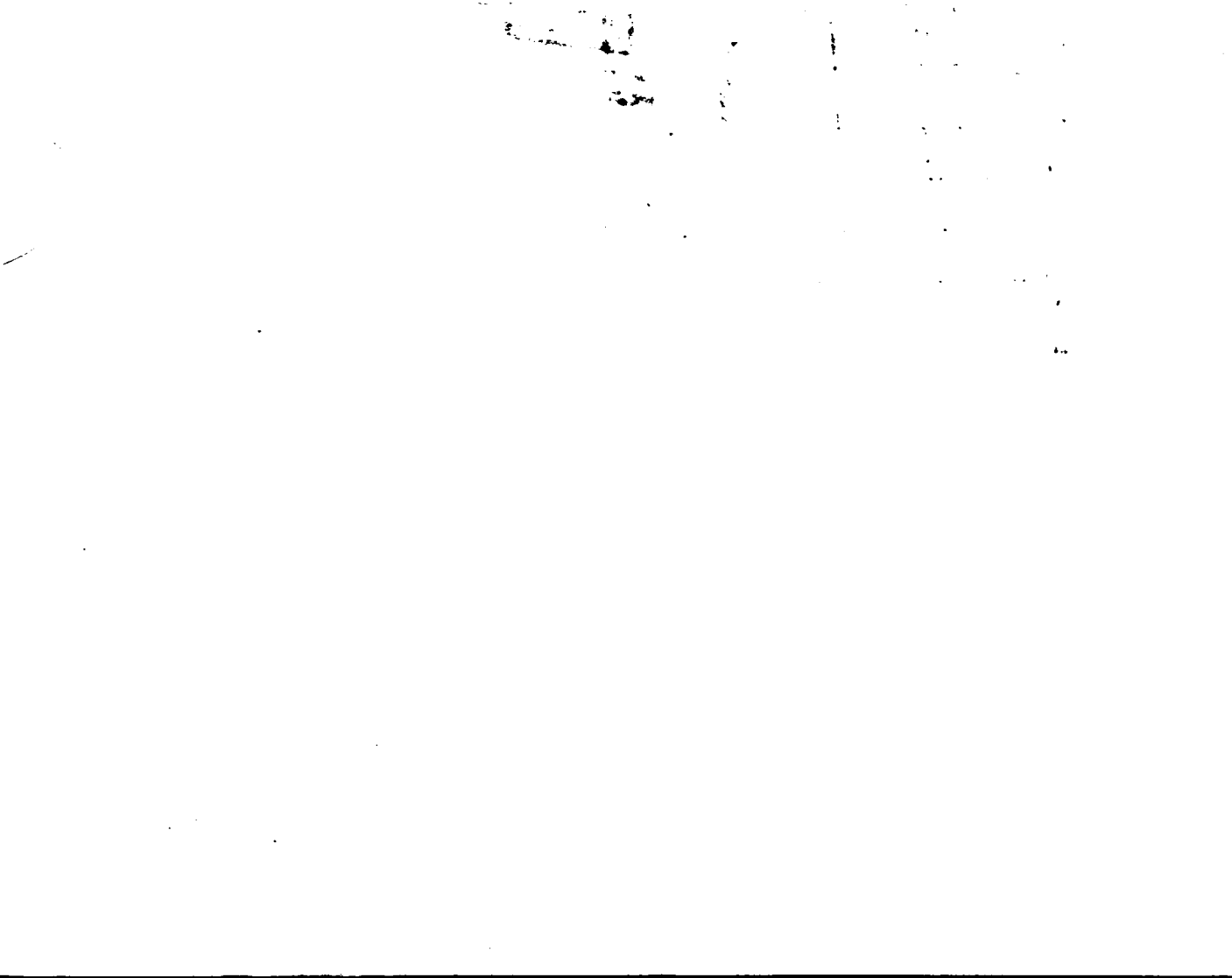
Given names added from a supplemental report.

..... 19

Address Salmon

..... 19

Filed July 10 1922 Chas Bellamy  
.....  
Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

29K-219103K-2493  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

AUG 4 1922

CERTIFICATE OF BIRTH

103291

County of Minidoka

City of Minidoka

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 19

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2015

Registered No. 119

Stillborn  
FULL NAME OF CHILD

Clara May Broadhurst

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>7-19-1922</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 1 Number of child of this mother now living, including present birth... 0

FATHER  
FULL NAME Chas. E. Broadhurst  
RESIDENCE Minidoka

MOTHER  
FULL MAIDEN NAME Maud Fay Dick  
RESIDENCE Minidoka

COLOR white AGE AT LAST BIRTHDAY 31  
(Years)

COLOR white AGE AT LAST BIRTHDAY 23  
(Years)

BIRTHPLACE Idaho

BIRTHPLACE Ky

OCCUPATION R. R. Employee Inspector

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_  
on the date above stated.

(Born alive or stillborn) 10 A.M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. E. Elmore

(Physician or midwife)

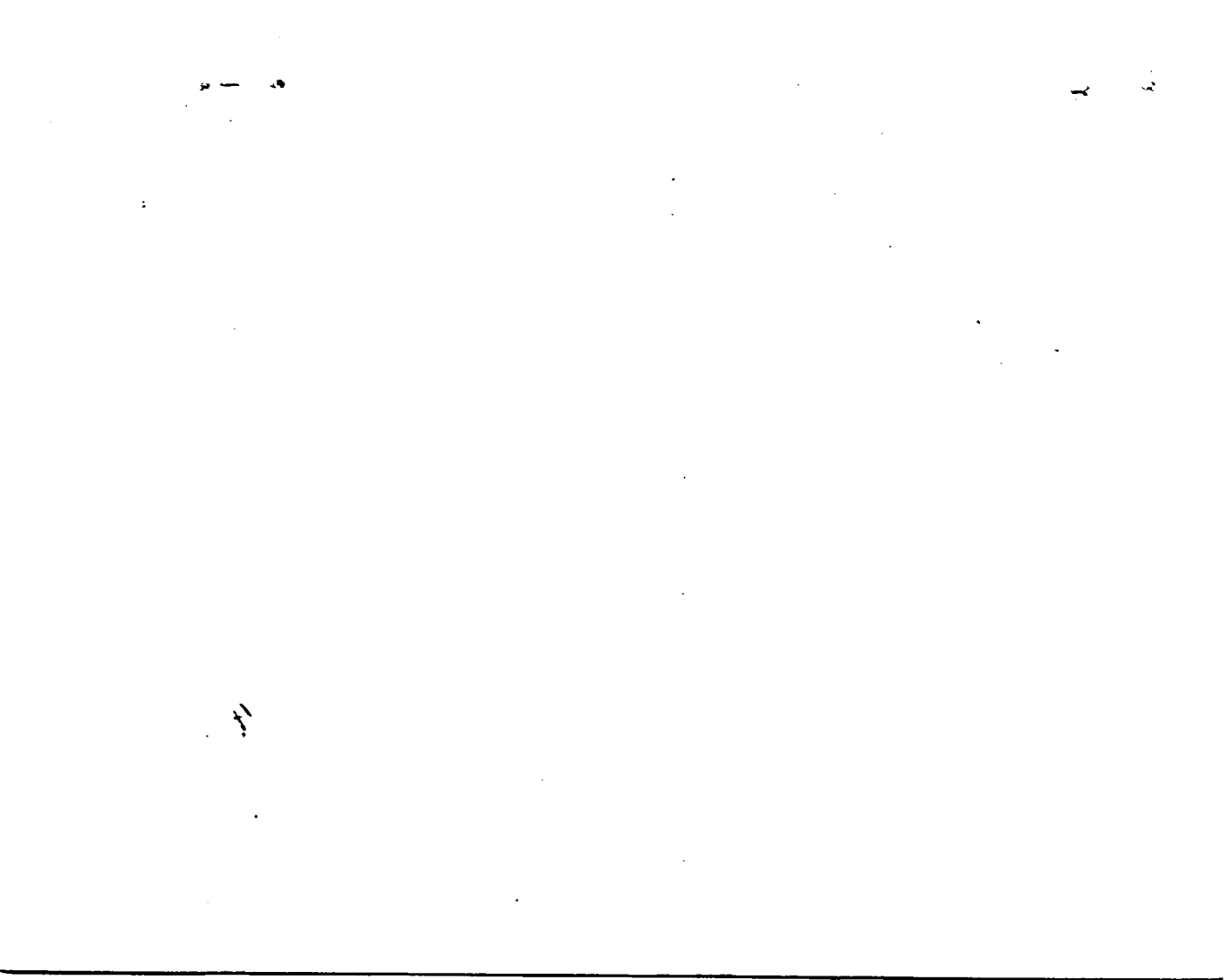
Give names added from a supplemental report.

Address \_\_\_\_\_

Filed 7-29-1922

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

County of Minidoka  
 City of Minidoka

Registration District No. 19Primary Registration District No. 2213

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 38764Registered No. 34

If death occurs away from  
 usual residence, give facts  
 called for under special  
 information.

## 2. FULL NAME

Clara May Broadhurst

If death occurred in a hos-  
 pital, institution or camp,  
 give its NAME instead of  
 street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

F

## 4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.Stillborn  
(Write the word.)

## 6. DATE OF BIRTH.

0 0 1  
 (Month) (Day) (Year)

## 7. AGE

Stillborn  
Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs. or  
 min.

## 8. OCCUPATION

(a) Trade, profession or  
 particular kind of work...  
 (b) General nature of in-  
 dustry, business, or estab-  
 lishment in which employ-  
 ed (or employer).....

## 9. BIRTHPLACE

(State or Country) Minidoka10. NAME OF  
FATHERChas. E. Broadhurst11. BIRTHPLACE  
OF FATHER(State or Country) Wyo12. MAIDEN NAME  
OF MOTHERMaud Fay Dlick13. BIRTHPLACE  
OF MOTHER(State or Country) Ky

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father

(Address) .....

## 15.

Filed 8-2 1912 E. T. Glavin  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

7 - 19 19122  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
7-19 19122 to 8-19 19122

that I last saw him alive on 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillborn due to breach  
 gestation without help(Duration) Yrs. mos. ds.Contributory  
(Secondary)(Duration) Yrs. mos. ds.(Signed) E. T. Glavin M. D.7-22 19122 (Address) Refert Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)  
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted  
if not at place of death?.....Former or  
usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

191

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

317-221-001-619  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Ada **RECEIVED**  
City of Bonanza **SEP 7 1922**  
No. St. Alphonsus **BUREAU OF VITAL STATISTICS**  
Hospital St. Alphonsus **Registration District No. 2** File No. **103492**  
Primary Registration District No. 1004 Registered No. 301  
FULL NAME OF CHILD Baby Ladner  
(Certificate of no value without full name of child.)

Sex of Child <u>7</u>	Twin Triplet or other? <u>and</u>	Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>Aug 21</u> 192 <u>2</u> (Month) (Day) (Year)
-----------------------	---	--------------------------------	------------------------	--

What bacteriocidal solution was used in eyes? Stillborn

Number of child of this mother, including present birth... 1 Number of child of this mother now living, including present birth... 0

FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
<u>Thomas J. Ladner</u>		<u>May Fairchild</u>	
RESIDENCE	<u>Placerville</u>	RESIDENCE	<u>Placerville</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>30</u> (Years)	AGE AT LAST BIRTHDAY	<u>24</u> (Years)
BIRTHPLACE	<u>Miner.</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Lumberman</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... Aug 21 at 3 A. M. M.  
on the date above stated. (Stillborn or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Jos. R. Manning, Jr.

(Physician or midwife)

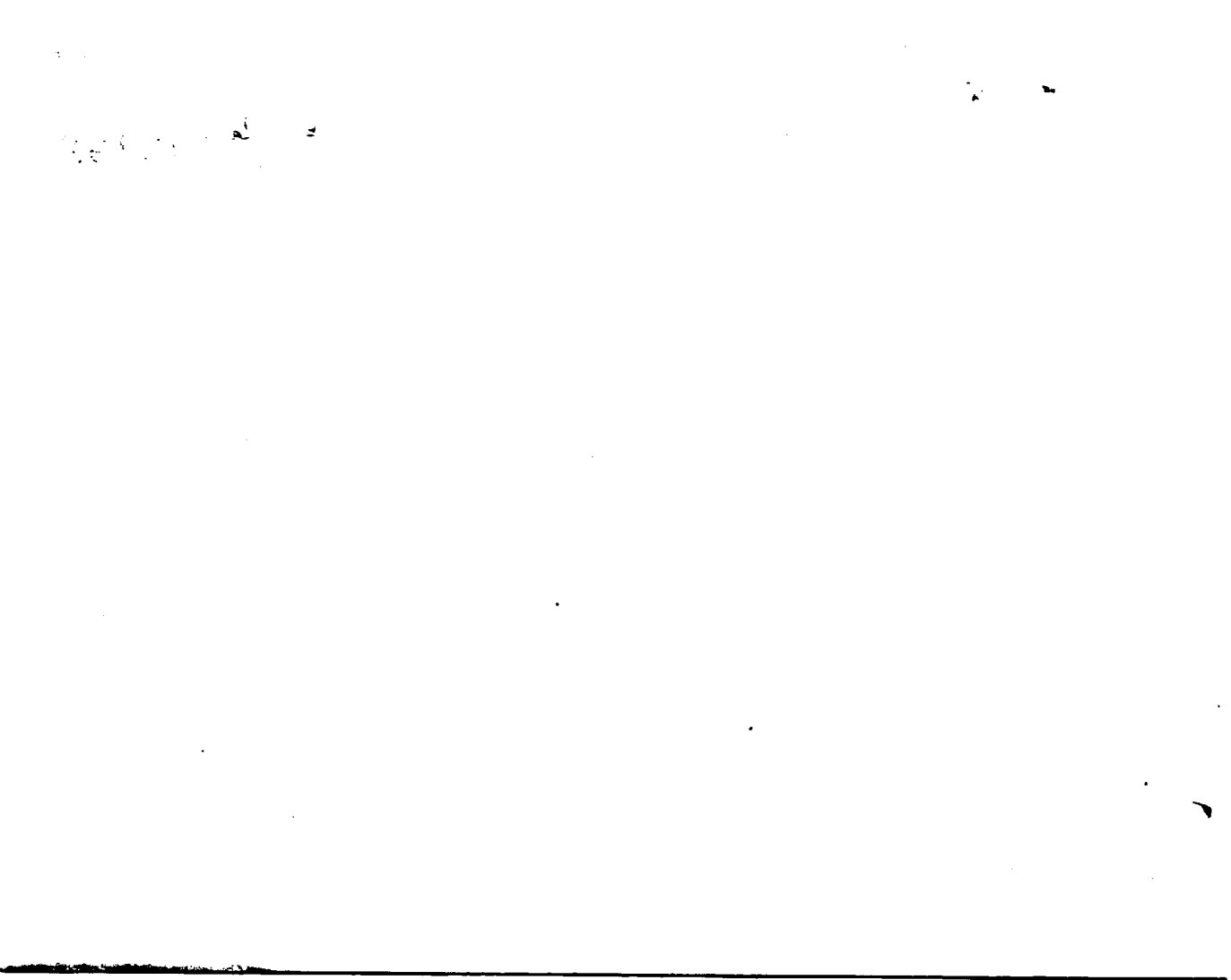
Give names added from a supplemental report.

Address Bonanza, Idaho

Filed Aug 25 1922 R. H. Rath

Registrar.

Registrar.



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Ada Registration District No. 3  
 City of Boise Primary Registration District No. 1004  
15 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Layden

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 38876  
 Registered No. 199

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single  
 (Write the word.)

## 6. DATE OF BIRTH

Aug 21<sup>st</sup> 1922  
 (Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
 how many..... hrs.  
 or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

none

## 9. BIRTHPLACE

(State or Country)

Boise, Idaho

## 10. NAME OF FATHER

Thos. F. Layden

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

May Fairchild

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. L. Layden

(Address)

Anteville, Idaho

## 15.

Filed

Aug 21 1922

R. H. Pad  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Aug 21<sup>st</sup> 1922  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Aug 21 1922 to Aug 21 1922  
 that I last saw her on Stillborn  
 and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

Stillborn

Stillborn

(Duration)..... Yrs..... mos..... ds.

Contributory.  
 (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) J. R. Rumburg M. D.

Aug 21 1922 (Address) Boise, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

St. Johns Cemetery 8/21 1922

## 20. UNDERTAKER

## ADDRESS

Schreiber & Hidenfaden (Boise)

Dr. Rumburg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*; *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

230-223-003-613  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

103526

80

County of Cassia **RECEIVED**  
City of Postville **AUG 17 1922**  
No. 1128 Harrison St. **BUREAU** Registration District No. 28 File No. 80  
Hospital Postville Primary Registration District No. 2161 Registered No. 4484  
FULL NAME OF CHILD Forby Louise Scott  
(Certificate of no value without full name of child.)

Sex of Child female Twin Triplet or other? no { and { Number in order of birth 1 Legitimacy yes Date of birth July 23 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth. 5 Number of child of this mother now living, including present birth. 4

FATHER  
FULL NAME Robert Franklin Scott  
RESIDENCE Postville Idaho  
COLOR white AGE AT LAST BIRTHDAY 41 (Years)  
BIRTHPLACE Rego, Arkansas  
OCCUPATION Boiler maker

MOTHER  
FULL MAIDEN NAME Ada Avara Watkins  
RESIDENCE Postville Idaho  
COLOR white AGE AT LAST BIRTHDAY 34 (Years)  
BIRTHPLACE La Fayette, Indiana  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

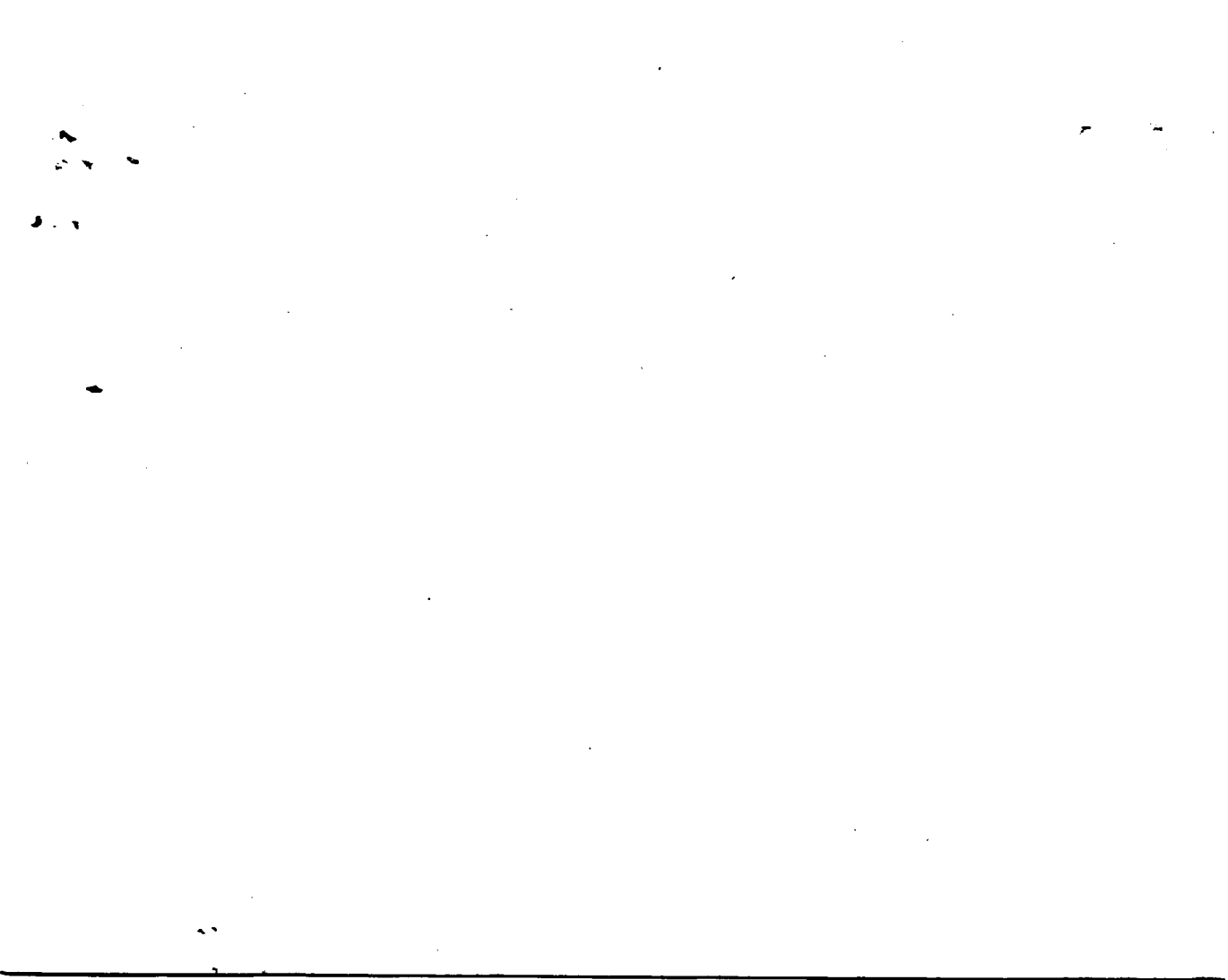
I hereby certify that I attended the birth of this child, who was stillborn at 11 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. B. Groves

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

(Physician or midwife)  
Address Postville Idaho  
Filed 8/1 1922 W. B. Groves Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

38878

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ba. mock  
City of Pocatello

Registration District No. 28  
Primary Registration District No. 2161  
St. W. H. Harrison

File No. 52  
Registered No. 3883

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH July 23 1922  
(Month) (Day) (Year)

7. AGE Still born IF LESS than 1 day how many hrs. min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work. none  
(b) General nature of industry, business or establishment in which employed (or employer) Pocatello Id

9. BIRTHPLACE Idaho  
(State or Country)

10. NAME OF FATHER R. H. Scott

11. BIRTHPLACE OF FATHER Arkansas  
(State or Country)

12. MAIDEN NAME OF MOTHER Fannie Cook

13. BIRTHPLACE OF MOTHER Mo.  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) R. H. Scott  
(Address) Pocatello, Idaho

15. Filed July 23 1922  
Local Registrar J. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 23 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from July 23 1922 to July 23 1922 that I last saw her alive on Stillborn 19... and that death occurred on the date stated above, at 11:22 A.M. The CAUSE OF DEATH\* was as follows:  
Still birth

(Duration) Yrs. mos. ds.  
Contributory (Secondary) Abruptio Placentae  
(Duration) yrs. mos. ds. Four hours  
(Signed) W. Brotherton M. D.  
7/23 1922 (Address) Pocatello Id

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death yrs. mos. days. In the State yrs. mos. days.  
Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mt View Cem DATE OF BURIAL July 23 1922  
20. UNDERTAKER Ed McHar ADDRESS Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

465-122-004-785  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
COUNTY OF Boise  
CITY OF Montpelier  
No. \_\_\_\_\_ St. \_\_\_\_\_  
HOSPITAL \_\_\_\_\_  
Primary Registration District No. 2136  
File No. 103564  
Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>Boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 22</u> 192 <u>2</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? Argyrol 10%

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

FATHER  
FULL NAME J. R. Montague  
RESIDENCE Montpelier  
COLOR W. AGE AT LAST BIRTHDAY 31 (Years)  
BIRTHPLACE Kansas  
OCCUPATION Barkeeper

MOTHER  
FULL MAIDEN NAME Anna Phelps  
RESIDENCE Montpelier  
COLOR W. AGE AT LAST BIRTHDAY 26 (Years)  
BIRTHPLACE Montpelier  
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was born premature at 7 P.M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. Geo. S. Ashley  
Montpelier, Ida.  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 192\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Pr 21/2  
Filed 192  
\_\_\_\_\_  
Registrar.

PLACE OF BIRTH

DEPARTMENT OF PUBLIC WELFARE

CERTIFICATE OF VITAL STATISTICS

CERTIFICATE OF BIRTH

108584

The No.

Registration District No.

Registration No.

Registration District No.

FULL NAME OF CHILD

Sex of Child	Male	Female
Color of Hair	Black	White
Color of Eyes	Blue	Brown
Color of Skin	White	Black
Weight at Birth	7.5	6.5
Length at Birth	20.0	19.0
Head Circumference at Birth	34.0	33.0
Birth Date	10/10/1910	
Birth Time	10:00	
Birth Place	Home	Hospital
Birth Certificate No.	108584	

Number of Children in Family	1
Number of Children in Household	1
Number of Children in Neighborhood	1
Number of Children in Community	1
Number of Children in Country	1
Number of Children in World	1

FATHER'S NAME	John Doe
MOTHER'S NAME	Jane Doe
FATHER'S OCCUPATION	Farmer
MOTHER'S OCCUPATION	Homemaker

DATE OF BIRTH	10/10/1910
TIME OF BIRTH	10:00
PLACE OF BIRTH	Home
NAME OF PHYSICIAN	Dr. John Doe

AGE	10
SEX	Male
RACE	White
RELIGION	Protestant
OCCUPATION	Student

CERTIFICATE OF A PHYSICIAN OR MIDWIFE	Dr. John Doe
DATE OF EXAMINATION	10/10/1910
PLACE OF EXAMINATION	Home
NAME OF PHYSICIAN	Dr. John Doe

STATE OF NEW YORK	10/10/1910
COUNTY OF ALBANY	10/10/1910
TOWN OF ALBANY	10/10/1910
WARD OF ALBANY	10/10/1910
STREET OF ALBANY	10/10/1910

NAME OF PHYSICIAN	Dr. John Doe
DATE OF EXAMINATION	10/10/1910
PLACE OF EXAMINATION	Home
NAME OF PHYSICIAN	Dr. John Doe

NAME OF PHYSICIAN	Dr. John Doe
DATE OF EXAMINATION	10/10/1910
PLACE OF EXAMINATION	Home
NAME OF PHYSICIAN	Dr. John Doe

863.117.004-386  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of

Bear Lake

City of

Montpelier

CERTIFICATE OF BIRTH

103565

No.

St.

Registration District No.

File No.

Hospital

Primary Registration District No.

Registered No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child

Boy

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti-  
mate?

Date of  
birth

July 17

1922

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Boric acid 5%

Number of child of this mother, including present birth

3

Number of children of this mother now living, including present birth

1

FULL  
NAME

FATHER

Con. H. Hotchkiss

FULL  
MAIDEN  
NAME

MOTHER

Reba Coffee

RESIDENCE

Montpelier

RESIDENCE

Montpelier

COLOR

W.

AGE AT LAST  
BIRTHDAY

35

(Years)

COLOR

W.

AGE AT LAST  
BIRTHDAY

31

(Years)

BIRTHPLACE

Iowa

BIRTHPLACE

Ill.

OCCUPATION

Salmon

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was

Still born

(Born alive or stillborn)

11 a.m.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. George F. Ashley

Montpelier

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

1922

Registrar.

Registrar.

SEVERAL REASONS WHY A CERTIFICATE  
FOR EACH CHILD AND THE SAME

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth	City .....	File Number .....
	Street .....	Registration Dist. No. ....
	County .....	
Sex of Child.....	Male	Date of Birth .....192....
Father .....	Full Name	Mother ..... Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Child's Name in Full

Signature of Father or Mother

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

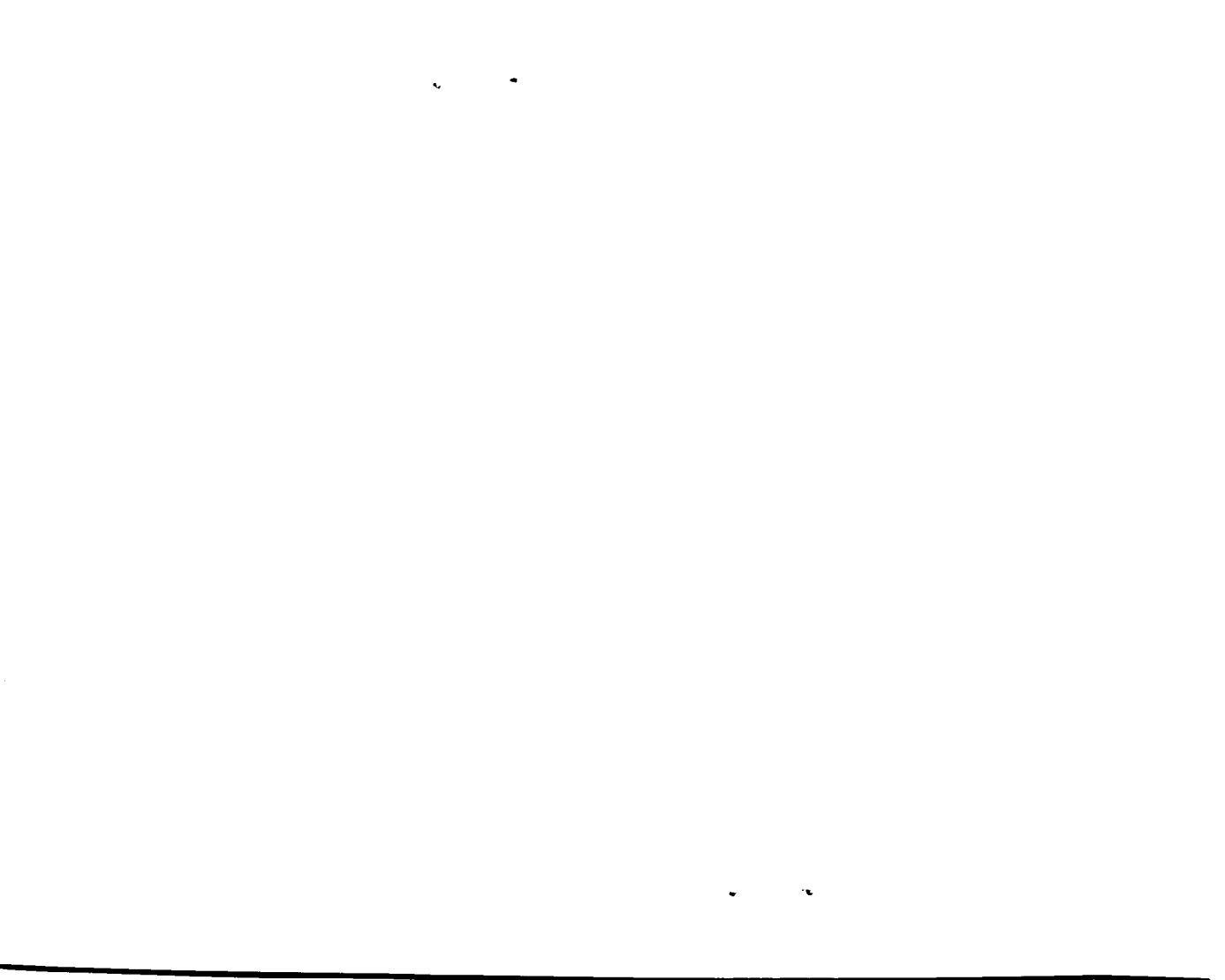
PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

**FILE # 103586**

**YEAR 1922**

**IDAHO STILLBIRTH CERTIFICATE**

**☒ VOID DUP OF STILLBORN  
1922-101972**





WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for  
each child, and the number of each, in order of birth stated.

42-0005-959  
No. of BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF VITAL STATISTICS

RECEIVED

JUN 17 1922

CERTIFICATE OF BIRTH

City of St. Maries Idaho  
No. 1144 College St. 32  
Hospital St. Maries Hosp Primary Registration District No. 2049 File No. S103601  
Registered No. 52

FULL NAME OF CHILD

Baby Cox

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? <u>  </u> and { Number in order of birth <u>  </u>	Legitimate? <u>yes -</u>	Date of birth <u>7-11-1922</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes?   

Number of child of this mother, including present birth 8 Number of children of this mother now living, including present birth 8

FATHER		MOTHER	
FULL NAME	<u>John F Cox</u>	FULL MAIDEN NAME	<u>Mary Rully</u>
RESIDENCE	<u>Fernwood</u>	RESIDENCE	<u>Fernwood</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>48</u> (Years)	AGE AT LAST BIRTHDAY	<u>48</u> (Years)
BIRTHPLACE	<u>Eastern Canada</u>	BIRTHPLACE	<u>Mandan N.D.</u>
OCCUPATION	<u>Logging</u>	OCCUPATION	<u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 6 35 P. M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Delonwall

(Physician or midwife)

Give names added from a supplemental report.

Address

St Maries Ida

Filed

8/9/1922

1922

Quiniger

Registrar.

Registrar.

STATEMENTS  
OF THE  
COMMISSIONERS  
OF THE  
LAND OFFICE

1895

1895

7

## 1. PLACE OF DEATH

County of *Bennett*City of *St. Maries*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Baby Cox*

## CERTIFICATE OF DEATH

Registration District No. *32*Primary Registration District No. *2049*

(No. \_\_\_\_\_ St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *38905*Registered No. *34*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED*single*  
(Write the word.)

## 6. DATE OF BIRTH

*July 12 1922*  
(Month) (Day) (Year)

## 7. AGE

*still-born*

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

*St Maries Ida*

## 10. NAME OF FATHER

*John F Cox*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Canada*

## 12. MAIDEN NAME OF MOTHER

*Mary R. Peilly*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*No placata*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Former Record Registrar Office*

## 15.

Filed *July 14 1922**Edmunds*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*July 12 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. L. H. H. H.* M. D.1/14 19 (Address) *St Maries*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Woodlawn* *7/14 1922*

## 20. UNDERTAKER

## ADDRESS

*Mitchell & Mearns* *St Maries Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

154-124-006-515  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Benewah AUG 1  
City of Shelley BUREAU OF VITAL STATISTICS  
No. \_\_\_\_\_ St. Registration District No. 121 File No. 103626  
Hospital \_\_\_\_\_ Primary Registration District No. 2144 Registered No. 308  
FULL NAME OF CHILD Le Roy Anderson  
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	Date of birth.	1922
	(To be answered only in event of plural births)			<u>Yes</u>	(Month) <u>July</u> (Day) <u>24</u> (Year)	

What bacteriocidal solution was used in eyes? no

Number of child of this mother, including present birth. \_\_\_\_\_ Number of child of this mother now living, including present birth. \_\_\_\_\_

FULL NAME <u>James Anderson</u>	FATHER	FULL MAIDEN NAME <u>Olga Galga Hansen</u>	MOTHER
RESIDENCE <u>Shelley Idaho</u>		RESIDENCE <u>Shelley Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Hennings</u>		BIRTHPLACE <u>Hennings</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born stillborn at 2 A M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

D. P. Egbert

Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address

Shelley Idaho

Filed

Aug 6 1922 Mr. [illegible]

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bingham Registration District No. 121  
City of Shelley Primary Registration District No. 2194  
(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Le Roy Anderson

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 38913  
Registered No. 120

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED Infant  
(Write the word.)

## 6. DATE OF BIRTH

July 24 1922  
(Month) (Day) (Year)

## 7. AGE

Infant Stillborn  
Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds. \_\_\_\_\_  
IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

## 9. BIRTHPLACE

(State or Country)

Shelley Ida,

## 10. NAME OF FATHER

James Anderson

## 11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

## 12. MAIDEN NAME OF MOTHER

Olga Halga Hansen

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Anderson  
(Address) Shelley

15. Filed July 25-22 Pro. Helen C. Peterson  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

July 24 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1922 to July 24 1922  
that I last saw him alive on July 24 1922,  
and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH\* was as follows:

Stillborn  
Prolapsed Cord

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. P. Robert M. D.

(Address) Shelley Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shelley 19

## 20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



294-123-007-469  
PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Donner

RECEIVED

AUG 11 1922

CERTIFICATE OF BIRTH

City of Priest River, Id.

Registration District No. 85

File No. 103646

No. — St. —

Primary Registration District No. 2185

Registered No. 198202

Hospital —

FULL NAME OF CHILD

Daniel Brumley

Sex of Child Male

Twin  
Triplet  
or other?

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti-  
mate?

yes

Date of  
Birth

July 23

1922

FULL  
NAME

FATHER  
Wm. Brumley

RESIDENCE

Priest River, Id.

COLOR

White

AGE AT LAST  
BIRTHDAY

36

(Years)

BIRTHPLACE

Missouri

OCCUPATION

Farmer

FULL  
MAIDEN  
NAME

MOTHER

Nellie Morehouse

RESIDENCE

Priest River, Id.

COLOR

White

AGE AT LAST  
BIRTHDAY

33

(Years)

BIRTHPLACE

Missouri

OCCUPATION

Housewife

Number of child of this mother, including present birth 8

Number of children of this mother now living, including present birth 7

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated.

at 11:00 P. M.  
(Born alive or stillborn)

(Signature)

Father of child  
Wm. Brumley

(Physician or midwife)

Address

Priest River, Idaho

Filed

August 1, 1922 C. T. Gett

Registrar.

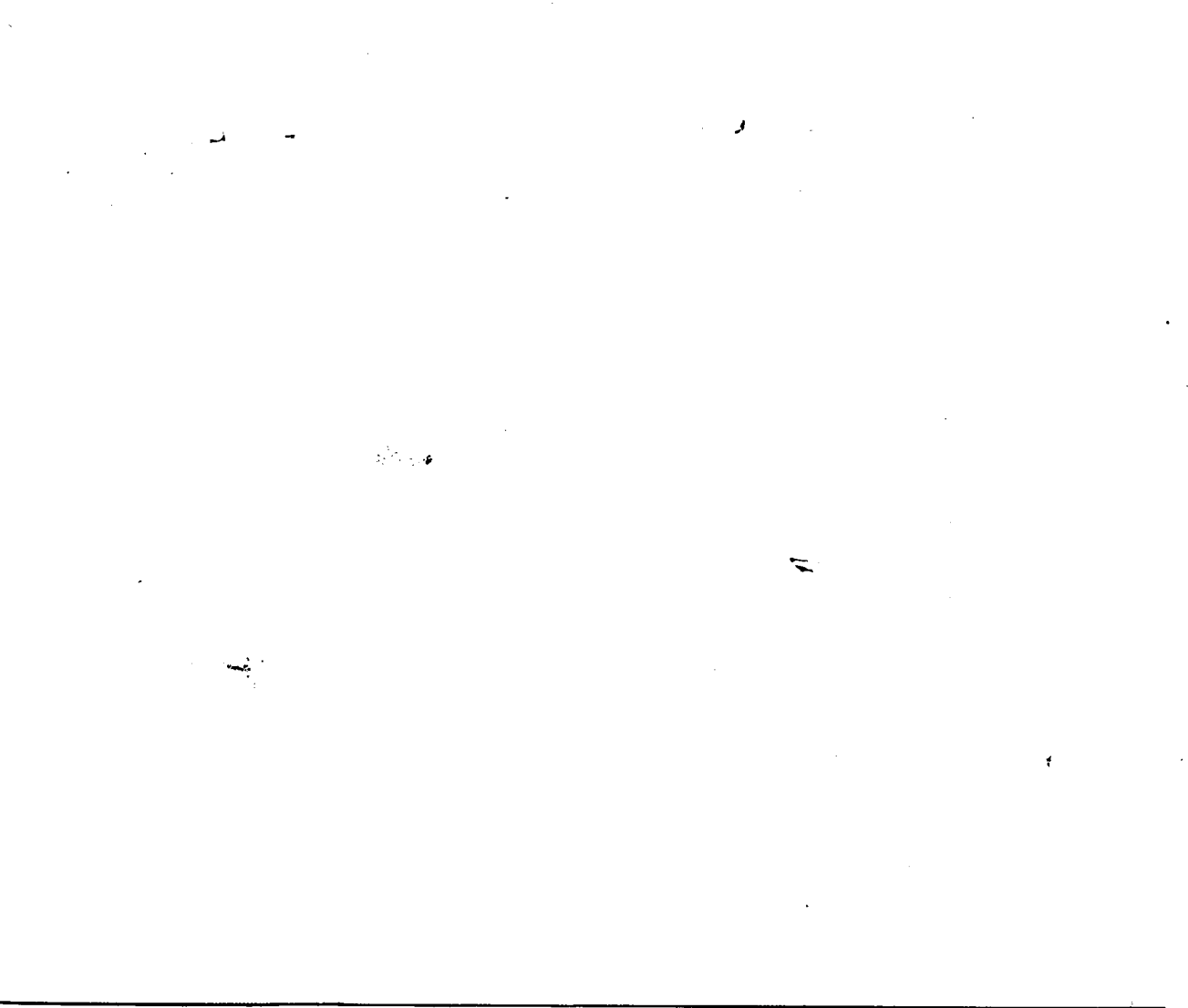
Registrar.

N. S.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

19



FORM V. S. No. 5-25 M. 1-19.

RECEIVED

AUG 17 1922

## CERTIFICATE OF DEATH

38941

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 3

Registered No. 65-

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of ConnerCity of Priest River, Ida

(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Daniel Brumley

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

## 6. DATE OF BIRTH

July 23

(Month)

(Day)

1922  
(Year)

## 7. AGE

\_\_\_\_ Yrs. \_\_\_\_ Mos. \_\_\_\_ ds.

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Wm. Brumley

## 11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

## 12. MAIDEN NAME OF MOTHER

Nellie Morehouse

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Brumley

(Address)

Priest River, Idaho

## 15.

Filed

August 1, 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

July

(Month)

23

(Day)

1922  
(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration)

Yrs.

mos.

ds.

Contributory  
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

C. F. Galt

M. D.

Aug 1, 1922

(Address)

Priest River, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Priest River, IdahoJuly 21, 1922

## 20. UNDERTAKER

## ADDRESS

Ind - Oscar MillerPriest River, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

819-212-009-363  
PLACE OF BIRTH

RECEIVED

SEP 10 1922

BUREAU OF VITAL  
STATISTICS

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

103657

County of Banner

City of Cabinet

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 80

File No. 2

Hospital \_\_\_\_\_

Primary Registration District No. 2157

Registered No. 57

FULL NAME OF CHILD

Lily Mabel Harris

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>8-12-1922</u> (Month) (Day) (Year)
----------------------------	---	-----------	--------------------------------	------------------------	--

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 0 ..... Number of child of this mother now living, including present birth... 0 .....

FATHER  
FULL NAME David Daniel Harris  
RESIDENCE Cabinet  
COLOR white  
AGE AT LAST BIRTHDAY 26  
(Years)  
BIRTHPLACE Brainard Minn.  
OCCUPATION Rancher

MOTHER  
FULL MAIDEN NAME Mary Jane Cochran  
RESIDENCE Cabinet  
COLOR white  
AGE AT LAST BIRTHDAY 35  
(Years)  
BIRTHPLACE Starbuck, Wn  
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) L. P. Stockhouse  
M.D.  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Sanapeing  
Filed 8-15 1922 Edm. Larson  
Registrar.

ADMINISTRATIVE OF

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City Cabinet Idaho.  
Street .....  
County Bonner

File Number 103657

Registration Dist. No. ....

Sex of Child Female Date of Birth Aug. 12 1922

Father David Daniel Harris Mother Mary Jane Cochran  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Lily Mabel Harris  
Child's Name in Full

Mrs. David D. Harris  
Signature of Father or Mother

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

# CERTIFICATE OF DEATH

38944

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**  
Registration District No. **80**  
County of **Bonner** Primary Registration District No. **2457**  
City of **Cabinet** St.)

File No. **1**  
Registered No. **31**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Harris**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH **August 12 - 1922**  
(Month) (Day) (Year)

7. AGE **Stillborn** IF LESS than 1 day how many hrs. or mins.?  
yrs. mos. ds.

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) **Cabinet, Ida.**

10. NAME OF FATHER **Daniel Daniel Harris**

11. BIRTHPLACE OF FATHER **Brainerd, Minn.**  
(State or Country)

12. MAIDEN NAME OF MOTHER **Mary Jane Cochran**

13. BIRTHPLACE OF MOTHER **Starbuck, Wn.**  
(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed **8-15-22** **J. M. Larson**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **August 12 - 1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191. to 191., that I last saw h. alive on 191., and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

**Stillborn**  
**Fast Presentation**  
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.  
(Signed) **B. Staehouse M. D.**  
**8-17-22** (Address) **Sandpoint**

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

**Cabinet** **8-13-22**  
20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill*; (a) *Salesman, (b) Grocery*; (a) *Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

113-220-010113

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

S

County of BonnevilleRECEIVED  
AUG 17 1922

CERTIFICATE OF BIRTH

City of UconBUREAU OF VITAL  
STATISTICS

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 73File No. 103666

Hospital \_\_\_\_\_

Primary Registration District No. 214-0 Registered No. 194

FULL NAME OF CHILD \_\_\_\_\_

Jackson

Sex of Child <u>Female</u>	Twins or other? <u>Triplets</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>5 20 22</u> (Month) (Day) (Year)
----------------------------	---------------------------------	-----	-----------------------------------	------------------------	--

FULL NAME <u>George Jackson</u>	FATHER
RESIDENCE <u>Ucon, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>5 0</u> (Years)
BIRTHPLACE <u>Nephi, Utah</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Bernice Jackson</u>	MOTHER
RESIDENCE <u>Ucon, Idaho</u>	
COLOR _____	AGE AT LAST BIRTHDAY <u>17</u> (Years)
BIRTHPLACE <u>Kemmer Myo</u>	
OCCUPATION <u>H. Wife</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Born dead, at 5 a. M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

(Physician or midwife)

Given names added from a supplemental report. \_\_\_\_\_

Address \_\_\_\_\_

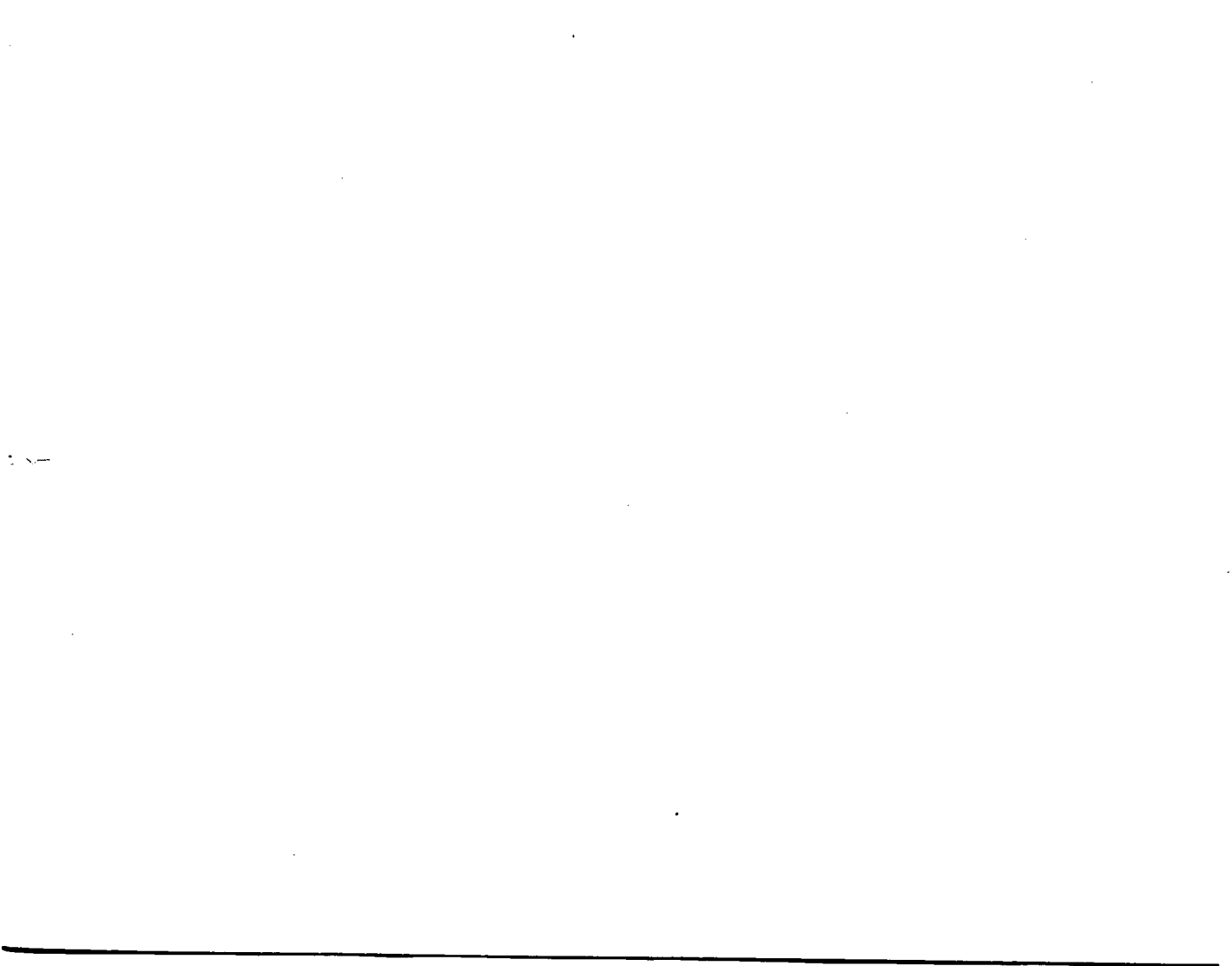
Filed July 2 19 22

Registrar \_\_\_\_\_

Registrar \_\_\_\_\_

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

255-12-014-315  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Canyon

City of Melba

No. \_\_\_\_\_

Registration District No. 2

File No. 103717

Hospital \_\_\_\_\_

Registration District No. 2

Registered No. 103717

FULL NAME OF CHILD Emily Craner Harrison Lewis

(Certificate of no value without full name of child.)

Sex of  
Child

Male

Twin  
Triplet  
or other?

{ and }

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti-  
mate?

Yes

Date of  
birth

July 2, 1922  
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth 14

Number of child of this mother now living, including present birth 11

FULL  
NAME

FATHER

William J. Craner

RESIDENCE

Melba, Ida

COLOR

White

AGE AT LAST  
BIRTHDAY

44  
(Years)

BIRTHPLACE

Utah

OCCUPATION

Laborer

FULL  
MAIDEN  
NAME

MOTHER

Luella Tanner

RESIDENCE

Melba, Ida

COLOR

White

AGE AT LAST  
BIRTHDAY

42  
(Years)

BIRTHPLACE

Utah

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

born dead, at 11:30 P. M.  
(Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature) \_\_\_\_\_

Samuel H. Swaine  
Melba, Ida  
(Physician or midwife)

Give names added from a supplemental report.

Address \_\_\_\_\_

Filed Aug 6 1922

James Lewis  
Registrar.

Registrar.

GENERAL REASON

CERTIFICATE OF BIRTH SHOL  
... WITH THE NO

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

1922  
VITAL  
STATISTICS

Place of Birth { City Melba  
Street .....  
County Canyon

File Number 103717

Registration Dist. No. ....

Sex of Child..... Male

Date of Birth July 21 1922

Father W. J. Craner  
Full Name

Mother Luella P. Tanner  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Harrison Levere Craner  
Child's Name in Full

Mrs. W. J. Craner  
Signature of Father or Mother

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.

10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.



## 1. PLACE OF DEATH

County of.....

City of.....

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## CERTIFICATE OF DEATH

Registration District No.....

Primary Registration District No.....

(State)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.....

Registered No.....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

## 6. DATE OF BIRTH

## 7. AGE

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(Address).....

## 15.

Filed.....

1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

## 17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

Diabetes — maternal  
9 mo. intrauterine gestation.  
Stillborn  
(Duration)..... Yrs..... mos..... ds.Contributory  
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

(Address).....

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Melba, Ida Cemetery

July 22 1922

## 20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

433-2291004-331 Country  
PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-9-8-17

103718

County of *Carson*

City of *Hammer*

No. *1607-S. 52 St.*

Registration District No. *7*

File No. *103718*

Primary Registration District No. *4.4.4*

Registered No. *103718*

Hospital *✓*

FULL NAME OF CHILD *X*

Sex of Child <i>girl</i>	Twin <i>✓</i> Triplet <i>✓</i> Quadruplet <i>✓</i> (To be answered only in event of plural births)	and { Number in order of birth <i>1</i> }	Legitimate? <i>yes</i>	Date of Birth <i>June 24 1927</i> (Month) (Day) (Year)
--------------------------	---	---	------------------------	---

FULL NAME FATHER *W. E. McCluskey*

RESIDENCE *Hammer R.R.*

COLOR *white* AGE AT LAST BIRTHDAY *27* (Years)

BIRTHPLACE *Kanawha*

OCCUPATION *Farmer*

FULL MAIDEN NAME MOTHER *Lucile Clark*

RESIDENCE *Hammer Basin*

COLOR *white* AGE AT LAST BIRTHDAY *21* (Years)

BIRTHPLACE *Idaho*

OCCUPATION *Housewife*

Number of child of this mother, including present birth *1* Number of children of this mother now living, including present birth *0*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was *still born* at *5:30* P. M. on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *M. D.*  
(Physician or midwife)

Given names added from a supplemental report.

Address *Hammer Idaho*

Filed *Aug 2 1927*

Registrar

Registrar

10-10

10-10

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 1  
County of Carson Primary Registration District No. 405  
City of Idaho Falls (No. 1 St.)File No. 38992Registered No. 1294

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED single  
(Write the word.)

## 6. DATE OF BIRTH

June 24 1922  
(Month) (Day) (Year)

## 7. AGE

✓ 0  
Yrs. Mos. ds. IF LESS than 1 day  
how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE Idaho  
(State or Country)10. NAME OF FATHER M. E. McCloskey11. BIRTHPLACE OF FATHER Kansas  
(State or Country)12. MAIDEN NAME OF MOTHER Lucile Clark13. BIRTHPLACE OF MOTHER South Dakota  
(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucile McCloskey  
(Address) Idaho Falls Idaho

## 15.

Filed Aug 5 1922 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

June 24 1922  
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased from at birth to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still born(Duration) ✓ Yrs. mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. P. Murray M. D.6/25/1922 (Address) Idaho Falls Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ✓ In the days. State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

433-224-014-331

PLACE OF BIRTH

County of *Campan*City of *Manassas*No. *607 S. 52* St.*Country*Registration District No. *7*Primary Registration District No. *2006*

Hospital .....

FULL NAME OF CHILD *X. J. McQuinn*

Sex of Child

*girl*

Twin

*Yes**Yes*

(To be answered only in event of plural births)

Number in order of birth

*2*

Legitimate?

*yes*

Date of Birth

*June 24 1922*  
(Month) (Day) (Year)

FULL NAME

*W. J. McQuinn*

FATHER

FULL MAIDEN NAME

*Lucile Clark*

MOTHER

RESIDENCE

*Manassas Rural*

RESIDENCE

*Manassas Rural*

COLOR

*White*

AGE AT LAST BIRTHDAY

*27*  
(Years)

COLOR

*white*

AGE AT LAST BIRTHDAY

*28*  
(Years)

BIRTHPLACE

*Illinois*

BIRTHPLACE

*S. Dakota*

OCCUPATION

*Farmer*

OCCUPATION

*Housewife*Number of child of this mother, including present birth *2* Number of children of this mother now living, including present birth *2*

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Still born 6 months 3 1/2 A. M.*  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *J. H. Murray*

(Physician or midwife)

Given names added from a supplemental report.

Address *Manassas Idaho*Filed *Aug 8 1922*

Registrar

Registrar

THE

DEPARTMENT OF THE ARMY

WASHINGTON, D. C.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED  
AUG 17 1922  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 38993

1. PLACE OF DEATH  
County of Canyon Registration District No. 7  
City of Nampa Registration District No. 2006  
(No. ) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant M. Crocker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Girl 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

6. DATE OF BIRTH June 24 1922  
(Month) (Day) (Year)

7. AGE 1 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Nampa Idaho  
(State or Country)

10. NAME OF FATHER W. S. McCloskey

11. BIRTHPLACE OF FATHER Rayon Idaho  
(State or Country)

12. MAIDEN NAME OF MOTHER Lucile Clark

13. BIRTHPLACE OF MOTHER South Dakota  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs. Lucile McCloskey  
(Address) Nampa Ida

15. Filed Aug. 8 1922 Pearl Dodds  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 24 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth to death, that I last saw him alive on June 24 1922, and that death occurred on the date stated above, at Nampa, M. The CAUSE OF DEATH\* was as follows:

Still born  
(Duration) Yrs. mos. ds.  
Contributory (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) J. H. Murray M. D.  
6/25 1922 (Address) Nampa, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Nampa DATE OF BURIAL 6/26 1922

20. UNDERTAKER none ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 8 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

519-240-014-318  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

103723

County of Canyon

RECEIVED

AUG 17 1922

Melba BUREAU OF VITAL STATISTICS

No. SL

District No. 7

File No.

Hospital 1

Primary Registration District No. 2006

Registered No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Varty

Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>July 10</u> 192 <u>2</u> (Month) (Day) (Year)
----------------------------	--	------------------------	---

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME <u>Joseph C. Varty</u>	FATHER
RESIDENCE <u>Melba, Ida.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u> </u> (Years)
BIRTHPLACE <u>Wisconsin</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Done B. Taylor</u>	MOTHER
RESIDENCE <u>Melba, Ida.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Illinois</u>	
OCCUPATION <u>House wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

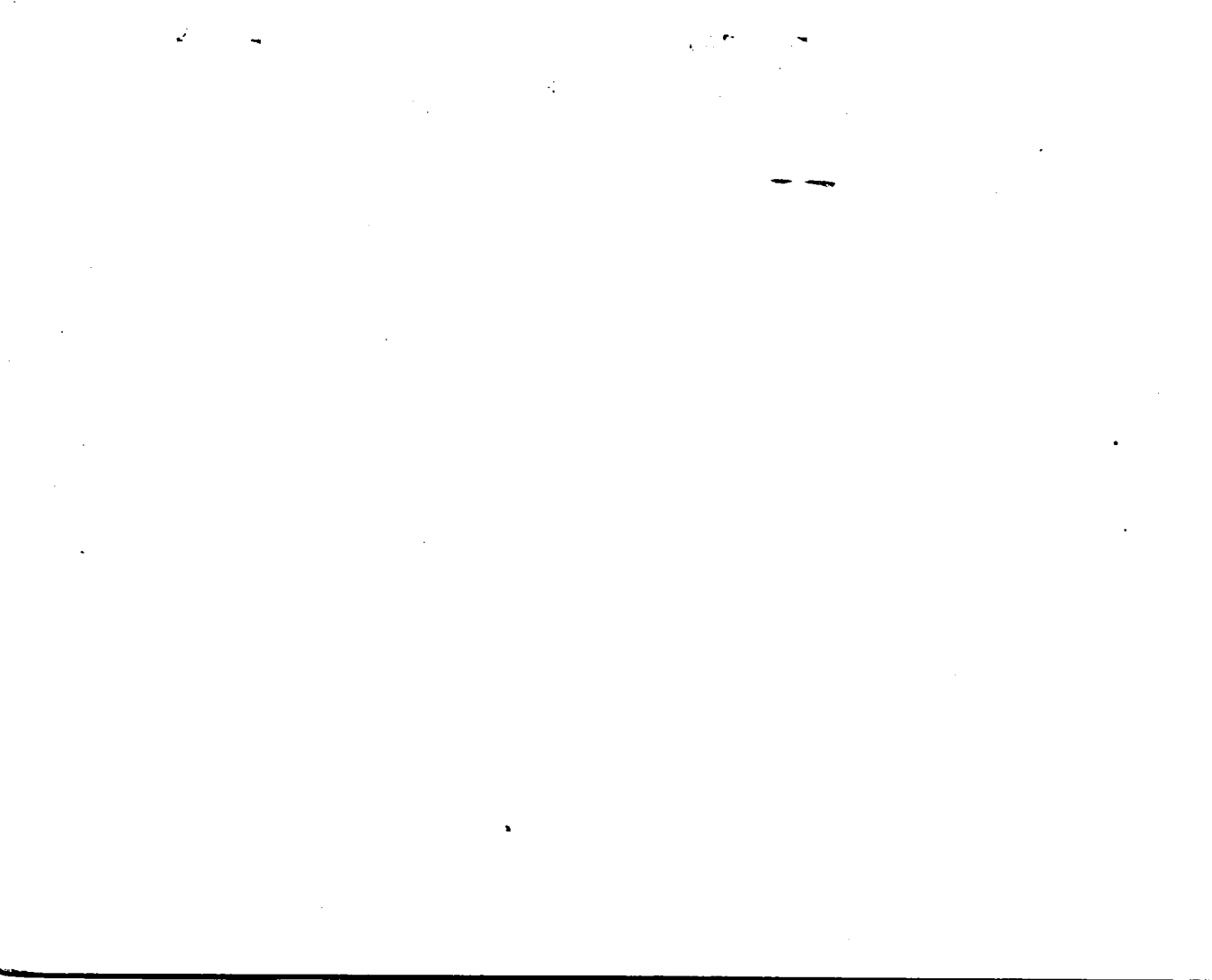
I hereby certify that I attended the birth of this child, who was Born dead at 7:30 P. M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Daniel A. Swaine  
Melba, Ida.  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address \_\_\_\_\_  
Filed Aug 8 1922 Pearle Dadds  
Registrar.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. **38995**

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**  
 County of Canyon Registration District No. 7  
 City or Melba Registration District No. 2006  
 State of Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Varty

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-  
 OWNED OR DIVORCED

Female | WhiteSingle  
(Write the word.)

6. DATE OF BIRTH

July 10 1922  
 (Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
 how many 0 hrs.  
 or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Canyon Co., Idaho

10. NAME OF FATHER

Joseph C. Varty

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Jane D. Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) x Mrs. Sam W. Taylor,  
 (Address) x Melba, Idaho.

15.

Filed Aug 8 1922 Pearce Dodd  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10 1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1922 to July 10 1922  
 that I last saw him alive on July 10 1922  
 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH\* was as follows:

Prolonged compression  
of head  
9 mos. utero gestation.  
 (Duration) 9 yrs. 0 mos. 0 ds.

Contributory  
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.  
 (Signed) Daniel Dwayne M. D.

July 11, 1922 (Address) Melba, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Melba, Ida.

DATE OF BURIAL

July 11, 1922

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

259-206-016-235  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Cassia **RECEIVED**  
City of Burley **AUG 15 1927**  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 117 File No. 103815  
Hospital \_\_\_\_\_ Primary Registration District No. 2196 Registered No. 2337  
FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>M</u>	Twin Triplet or other? _____ { and } Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>July 6</u> 192 <u>7</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth \_\_\_\_\_ Number of child of this mother now living, including present birth \_\_\_\_\_

FATHER		MOTHER	
FULL NAME	<u>R. R. Berlin</u>	FULL MAIDEN NAME	<u>Jessie Stewart</u>
RESIDENCE	<u>Burley, Ida.</u>	RESIDENCE	<u>Burley, Ida.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>27</u> (Years)	AGE AT LAST BIRTHDAY	<u>27</u> (Years)
BIRTHPLACE	<u>neb.</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>mechanic</u>	OCCUPATION	<u>Ill.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 4 a. M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

\_\_\_\_\_, 19\_\_\_\_

Registrar.

(Signature)

Address

Filed

Dr. J. C. Patterson

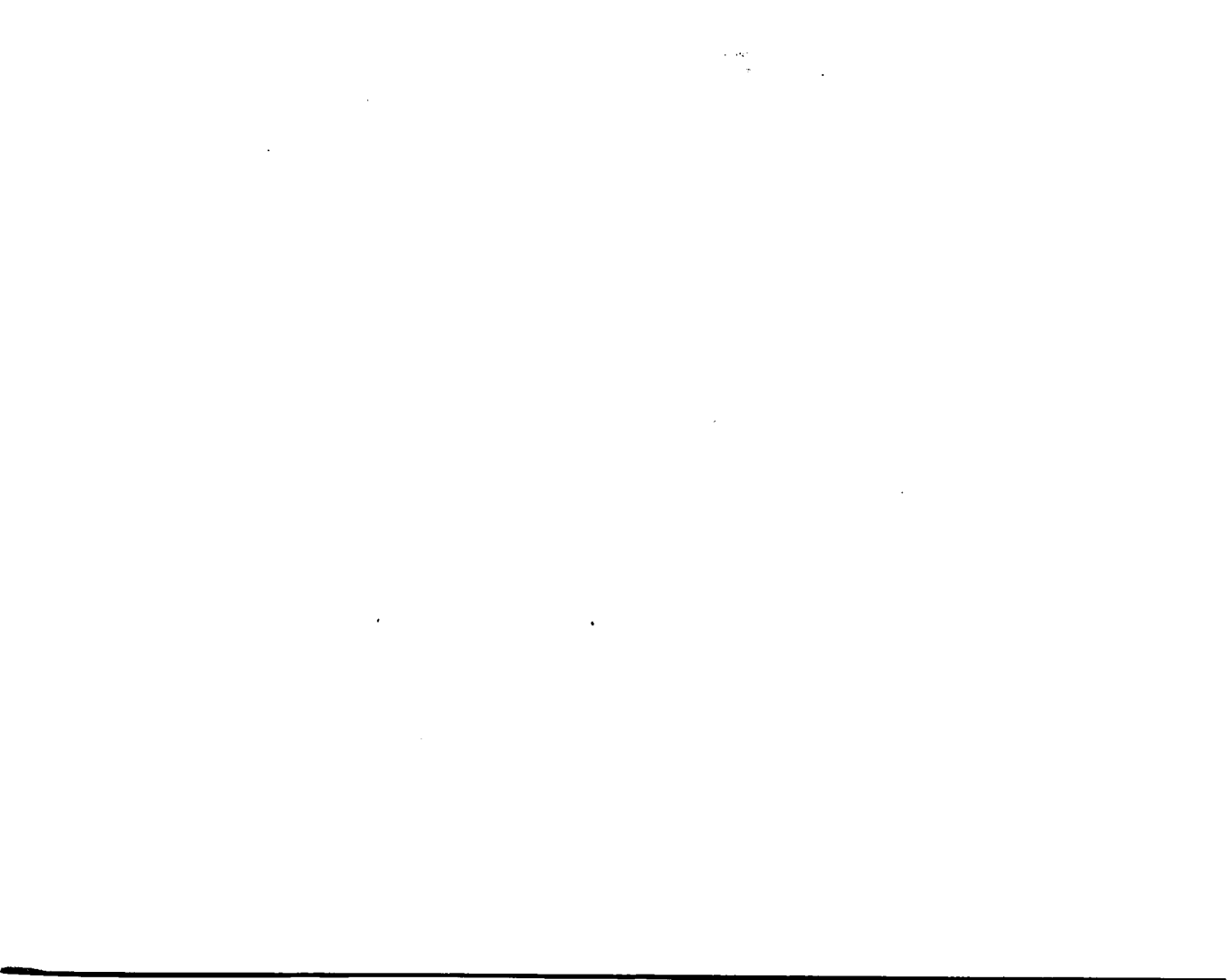
(Physician or midwife)

Burley, Idaho

July 27, 1927

Dr. J. C. Patterson

Registrar.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at a birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated

289-108-020-453  
PLACE OF BIRTHCounty of ElmoreCity of Elmer's Ferry Idaho

No. \_\_\_\_\_ St. \_\_\_\_\_

RECEIVED  
SEP 7 1922  
BUREAU OF VITAL  
STATISTICSSTATE OF IDAHO  
Bureau of Vital Statistics  
CERTIFICATE OF BIRTH

Form V. S. No. 11-10m-6-20-11

S

File No. 103861Primary Registration District No. 2021

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD Unnamed

Sex of Child <u>Male</u>	Twin, Triplet, or other? <u>Single</u>	and (Number in order of birth) <u>3</u>	Legitimate? <u>yes</u>	Date of birth <u>July 8</u> , 1922 Month (Day) (Year)
--------------------------	--	---	------------------------	--

FATHER FULL NAME <u>Ralph B. Burren</u>	MOTHER FULL MAIDEN NAME <u>Myrtle Slicker</u>
RESIDENCE <u>Elmer's Ferry Idaho</u>	RESIDENCE <u>Elmer's Ferry Idaho</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>23</u> (Years)	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Missouri</u>	BIRTHPLACE <u>Missouri</u>
OCCUPATION <u>Wherry Club</u>	OCCUPATION <u>Housewife</u>

Number of child of this mother, including present birth 3Number of children, of this mother, now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Still Born July 8, 1922 at 12:30 A.M.  
(Resembling a stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

J. W. Davis M.D.

Given name added from a supplemental report

Address \_\_\_\_\_

Filed Jul

7-10-68

1968

“... 1990”

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

# CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 35

County of Emmon

Bureau Registration District No. 2021

City of Glenn's Ferry

(No. STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

unnamed

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 39036

Registered No. ....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single  
(Write the word.)

6. DATE OF BIRTH

July 8 1922  
(Month) (Day) (Year)

7. AGE

Still Born  
yrs. .... mos. .... ds.

IF LESS than 1 day  
how many .... hrs. or  
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work ....  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Ralph Byrum

11. BIRTHPLACE OF FATHER

(State or Country) America

12. MAIDEN NAME OF MOTHER

Myrtle Becker

13. BIRTHPLACE OF MOTHER

(State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ralph Byrum

(Address) Glenn's Ferry Idaho

15.

Filed July 9 1922 J. W. Davis  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 8 1922  
Still Born  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Still Born 191....., to 191.....  
that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

Unknown to me

(Duration) .... yrs. .... mos. .... ds.

Contributory (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) J. W. Davis M. D.

July 9 1922 (Address) Glenn's Ferry Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death..... yrs. .... mos. .... ds. State..... yrs. .... mos. .... ds.

Where was Disease contracted,

If not at place of death? .....

Former or usual residence. ....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenn's Ferry Idaho July 9 1922

20. UNDERTAKER

ADDRESS

Ralph Byrum Glenn's Ferry Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

396-106-025

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

103910

County of IdahoCity of CottonwoodRegistration District No. 185File No. 710

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2183

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Edward Junior CrowSex of  
ChildMaleTwin  
Triplet  
or other?  
(To be answered only in event of plural births)

{ and }

{ Number  
in order  
of birth }Legiti  
mate?  
yesDate of  
BirthJuly 6

(Month) (Day)

(Year) 1922FULL  
NAMEHarry Crow

FATHER

RESIDENCE

Boles Ida.

COLOR

W.AGE AT LAST  
BIRTHDAY36

(Years)

BIRTHPLACE

Idaho.

OCCUPATION

FarmersFULL  
MAIDEN  
NAMEHella Hallingsworth

MOTHER

RESIDENCE

Boles Ida.

COLOR

W.AGE AT LAST  
BIRTHDAY20

(Years)

BIRTHPLACE

Idaho.

OCCUPATION

HousewifeNumber of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 7 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Dr. Wesley F. Orr

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Cottonwood Ida.

Filed

July 31 1922W. F. Orr

Registrar

Registrar



## CERTIFICATE OF DEATH

39043

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Idaho AUG 17 1922  
County of Idaho  
City of Cottonwood

Registration District No.

Registration District No.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Edward Junior Crow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

July 6 1922  
(Month) (Day) (Year)

## 7. AGE

Still birth  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed July 31 1922 W. F. Orr  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

July 6 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Still birth. Long protracted labor.

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wesley F. Orr M. D.

7/6 1922 (Address) Cottonwood, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cottonwood Ida 7-6 1922

## 20. UNDERTAKER

ADDRESS

A. H. Mann Cottonwood Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

632-104029-386

PLACE OF BIRTH

RECEIVED

Form V. S. No. 11-C--25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of Latato

DUE

CERTIFICATE OF BIRTH

S103958

City of Deary

Registration District No. 2147

File No. 7

No. \_\_\_\_\_

St. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 67

Registered No. 10

FULL NAME OF CHILD

Charles Otto Olson

Sex of Child

M.

Twin  
Triplet  
or other? ✓

and

Number  
in order  
of birth ✓

(To be answered only in event of plural births)

Legiti  
mate? yes

Date of  
Birth

Aug 4 1922  
(Month) (Day) (Year)

FULL  
NAME

Andrew Olson

FATHER

FULL  
MAIDEN  
NAME

Helen Thompson

MOTHER

RESIDENCE

Deary

RESIDENCE

Deary

COLOR

W.

AGE AT LAST  
BIRTHDAY

27  
(Years)

COLOR

W.

AGE AT LAST  
BIRTHDAY

20  
(Years)

BIRTHPLACE

S. Dak.

BIRTHPLACE

Ida.

OCCUPATION

laborer

OCCUPATION

H.W.

Number of child of this mother, including present birth 3

Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 10:18 A.M. on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

P. C. Faust  
physician

(Physician or midwife)

Given name added from a supplemental report.

Address

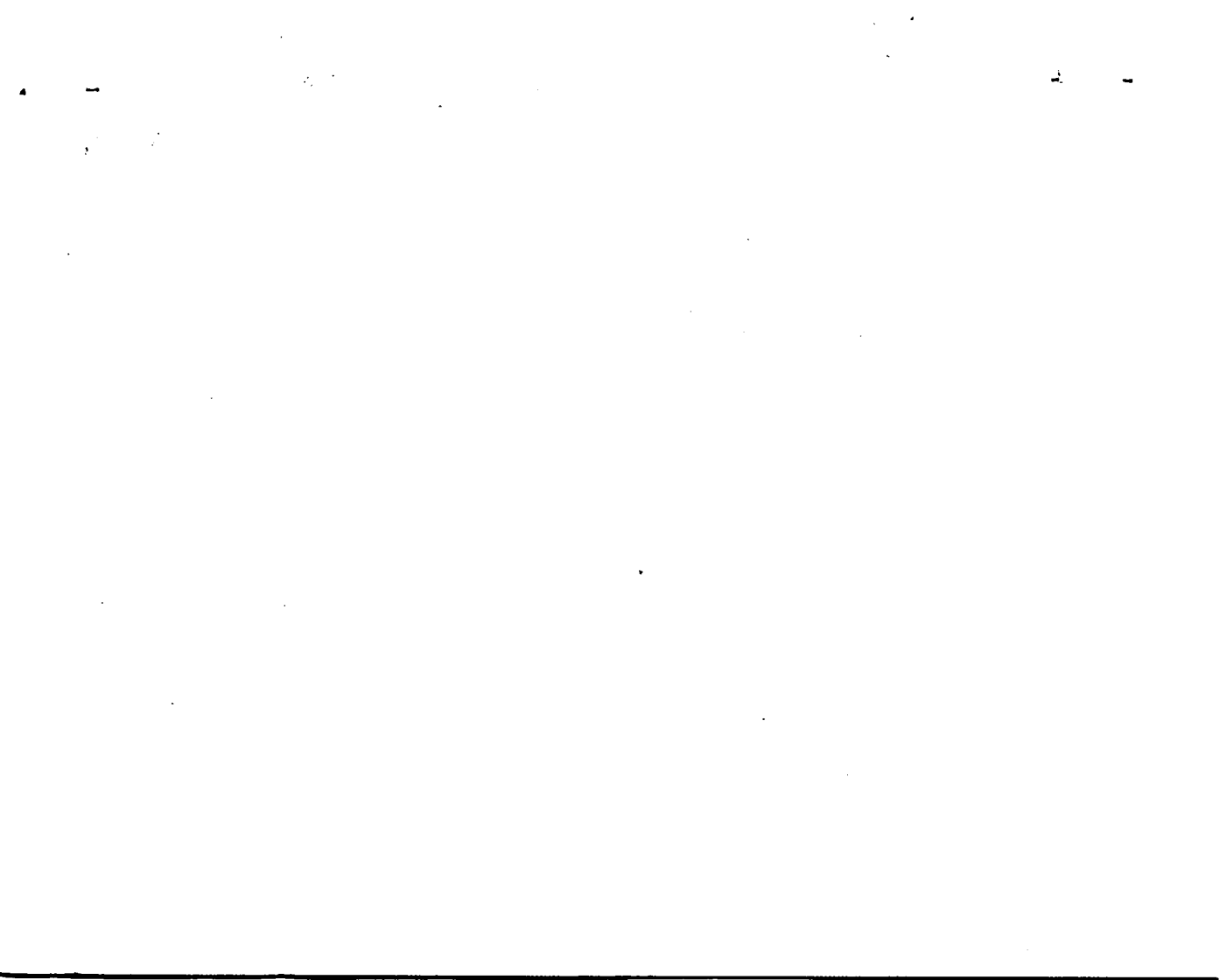
Deary

Filed

8/4 1922

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED  
AUG 17 1922

CERTIFICATE OF DEATH

39078

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Otto Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

(Duration) Yrs. mos. ds.  
Contributory (Secondary) Difficult Delivery

(Duration) Yrs. mos. ds.  
(Signed) P. B. Faust M. D.

(Address) Deary

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

893101-04 893 RECEIVED  
PLACE OF BIRTH  
SEP 5 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Latah

City of Victor

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Registration District No. 77

Primary Registration District No. 2176

File No.

S104128

Registered No. 73

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth... <u>Aug 1</u> 1922 (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? Nothing

Number of child of this mother, including present birth... \_\_\_\_\_ Number of child of this mother now living, including present birth... 0

FATHER		MOTHER	
FULL NAME	<u>L. E. Brown</u>	FULL MAIDEN NAME	<u>Mabel Hill</u>
RESIDENCE	<u>Unknown</u>	RESIDENCE	<u>Victor, Id.</u>
COLOR	_____	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY (Years)	_____	AGE AT LAST BIRTHDAY (Years)	<u>17</u>
BIRTHPLACE	_____	BIRTHPLACE	<u>Id.</u>
OCCUPATION	_____	OCCUPATION	<u>Working Girl</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4 P. M.  
on the date above stated. (Born alive or stillborn)

{ \*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Signature) Chas. J. Martin

Physician or midwife

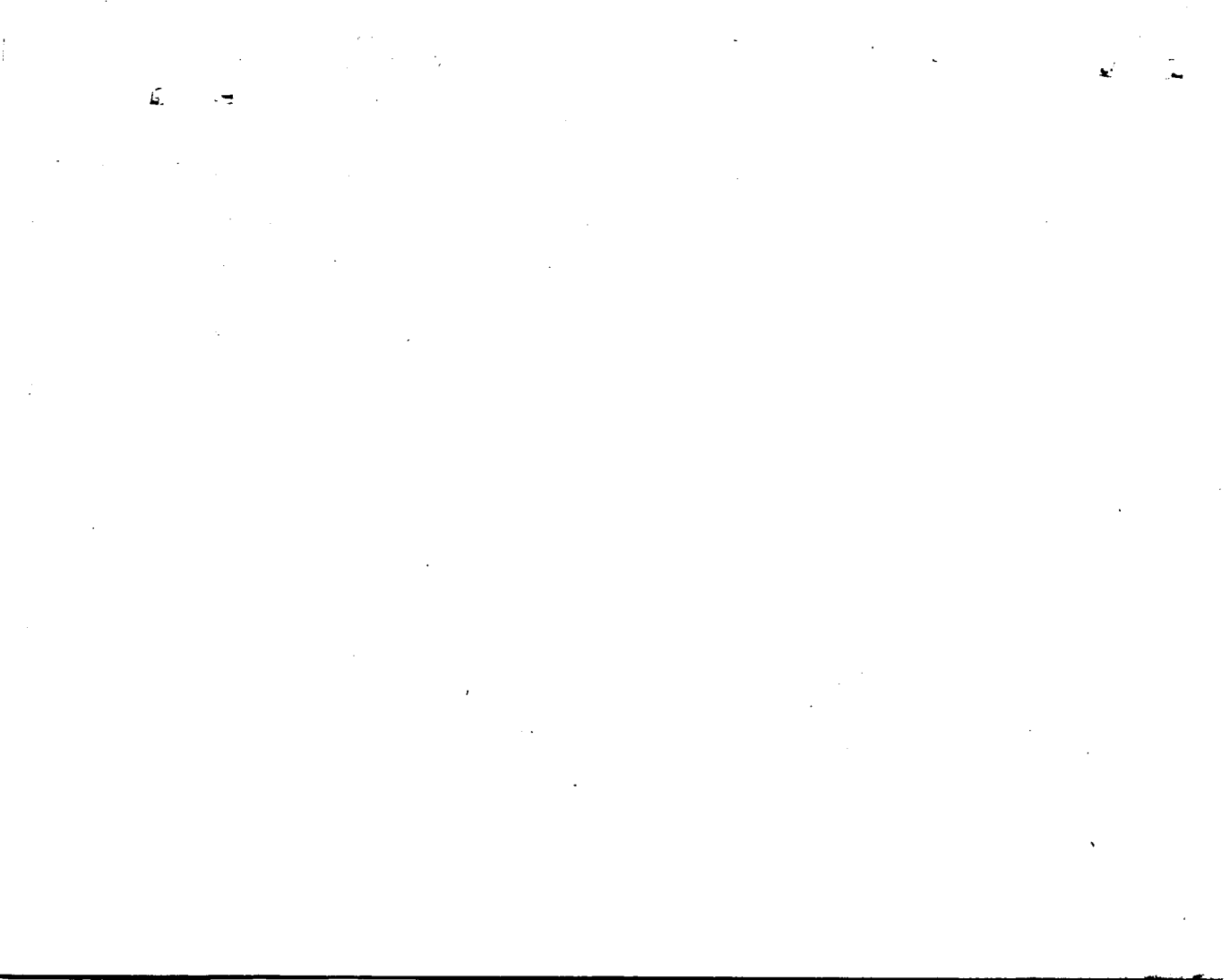
Give names added from a supplemental report.

Address Victor, Id.

Filed Aug 30 1922

Martha Marker  
Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

## 1. PLACE OF DEATH

County of VictorCity of Victor

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## CERTIFICATE OF DEATH

Registration District No. 77Primary Registration District No. 2176

St.)

File No.

39119Registered No. 15State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write in word.)

## 6. DATE OF BIRTH

Aug 1  
(Month) (Day) (Year)

## 7. AGE

Stillborn  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).Infant.

## 9. BIRTHPLACE

(State or Country)

Victor, Id.

## 10. NAME OF FATHER

Unknown

## 11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

## 12. MAIDEN NAME OF MOTHER

Mabel Hill

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs G. W. Leary  
Victor, Id.

(Address)

## 15.

Filed Aug 20th 1922Martha Marker  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Aug 1 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 1922 to Aug 1 1922  
that I last saw him alive on Aug 1 1922

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Chas. Martin M. D.Aug 2 1922 (Address) Victor, Id.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Victor, Idaho Aug 21 1922

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each,  
and the number of each, in order of birth stated.

442-216-104-997  
PLACE OF BIRTH

RECEIVED

SEP 5 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

104129

County of Latah

City of Driggs R.D.

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

Registration District No. 77

File No. \_\_\_\_\_

Primary Registration District No. 3176

Registered No. 87

FULL NAME OF CHILD

Ada Austin

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and (in order of birth)	Legiti- mate? <u>yes</u>	Date of birth. <u>July 16</u> 192 <u>2</u> (Month) (Day) (Year)
----------------------------	---	-------------------------------	-----------------------------	---

What bacteriocidal solution was used in eyes? 10% Argol

Number of child of this mother, including present birth... 2 Number of child of this mother now living, including present birth... 1

FULL NAME <u>Norma Austin</u>	FATHER
RESIDENCE <u>Driggs R.D.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>farmer</u>	

FULL MAIDEN NAME <u>Martha Ripplinger</u>	MOTHER
RESIDENCE <u>Driggs R.D.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 7 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Clayton Marker  
Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address

Driggs, Idaho

Filed

Aug 30 1922

Martha Marker

Registrar.

Registrar.

NO ME 1944

AL REASONS WHY A CERTAIN

CHILD AND THE SAME COM

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Driggs*  
Street .....  
County *Leton*

File Number *1041289*

Registration Dist. No. ....

Sex of Child *Female*

Date of Birth *July 16* 1922

Father *Norma Austin*  
Full Name

Mother *Martha L. Rippinger*  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Ada Austin*  
Child's Name in Full

*Norma Austin*  
Signature of Father or Mother

- - - - -

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

SEP 5 1922

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of TetonCity of Driggs, R.D.

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Registration District No. 77Primary Registration District No. 3176

(No. \_\_\_\_\_) (St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 39122Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX \_\_\_\_\_ 4. COLOR OR RACE \_\_\_\_\_ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED \_\_\_\_\_

(Write the word.)

6. DATE OF BIRTH

(Month) July (Day) 16 (Year) 1922

7. AGE

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Aug 30 - 1922Martha Marker  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) July (Day) 16 (Year) 1922

17. I HEREBY CERTIFY, That I attended deceased from

July 16, 1922, to July 16, 1922

that I last saw him alive on July 16, 1922

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Signed)

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

251-10-041-113

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH **RECEIVED**  
 County of Idaho **SEP 5 1922**  
 City of Brigida **BUREAU OF VITAL STATISTICS**  
 Registration District No. 77 **CERTIFICATE OF BIRTH**  
 File No. **S 104131**  
 No. \_\_\_\_\_ St. \_\_\_\_\_  
 Primary Registration District No. 9176 Registered No. 75-  
 Hospital \_\_\_\_\_  
 FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>Male</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>Sept 1 1922</u> (Month) (Day) (Year)
FULL NAME <u>John Van Beek</u>	FATHER	FULL MAIDEN NAME <u>Opal Jackson</u>	MOTHER	
RESIDENCE <u>Brigida Ida</u>		RESIDENCE <u>Brigida Ida</u>		
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>		
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>		
Number of child of this mother, including present birth _____		Number of children of this mother now living, including present birth _____		

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\***

I hereby certify that I attended the birth of this child, who was still born, at 1 P. M. on the date above stated.  
 (Born alive or stillborn)

(Signature) Chas. J. Martin  
 Physician or midwife

Given names added from a supplemental report. \_\_\_\_\_ 19\_\_\_\_  
 Address Brigida Ida  
 Filed Aug 30 1922 Martha Warner  
 Registrar

Registrar

Filed

Accepted

Given names added from a supplemental report.

When there was no attending physician or midwife then the father, grandmother, brother, sister, or other person who attended the birth of the child should make this report. A registered child is one that has been registered and shows other evidence of the birth.

I hereby certify that I attended the birth of this child, who was (Name of child or stillborn)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

Number of child of this mother, including present birth. Number of children of this mother now living, including present birth.

OCCUPATION

OCCUPATION

BIRTHPLACE

BIRTHPLACE

AGE AT LAST BIRTHDAY

COLOR

COLOR

RESIDENCE

RESIDENCE

FATHER'S NAME

FULL NAME

(To be answered only in event of plural births)

Old

Twin

and in order

Number

Left

mate?

Date of Birth

(Month) (Day) (Year)

MOTHER'S

FULL NAME

MAIDEN NAME

RESIDENCE

AGE AT LAST BIRTHDAY

(Year)



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Elmore Registration District No. 77  
 City of Elmore Primary Registration District No. 2176 St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 39117  
 Registered No. 39117

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE MARRIED, WIDOWED OR DIVORCED Single

## 6. DATE OF BIRTH

May 1 1922  
 (Month) (Day) (Year)

## 7. AGE

Stillborn IF LESS than 1 day  
 how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Elmore, Idaho

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country) Italy

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Beard

(Address) Elmore, Idaho

## 15.

Filed Aug 30 - 1922 Martha Marker  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Stillborn 1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1922 to May 1 1922  
 that I last saw him alive on May 1 1922  
 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH\* was as follows:

Still-born

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. Martin

May 2 1922 (Address) Elmore, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Pratt Cemetery May 2nd 1922

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

155-247-042-93

## PLACE OF BIRTH

County of *Twain Falls*City of *Rogerson*

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child *Girl* Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legitimate? *yes* Date of Birth *7/27* 19*22* (Month) (Day) (Year)FATHER  
FULL NAME *Christian Emerson Jensen*RESIDENCE *Rogerson*COLOR *White* AGE AT LAST BIRTHDAY *27* (Years)BIRTHPLACE *Utah*OCCUPATION *Forest Ranger*

Number of child of this mother, including present birth, \_\_\_\_\_

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-1-1-18

## CERTIFICATE OF BIRTH

S104133

No. *37*

File No. \_\_\_\_\_

Primary Registration District No. *2085*

Registered No. \_\_\_\_\_

*Jensen*MOTHER  
FULL MAIDEN NAME *Dora Willis*RESIDENCE *Rogerson*COLOR *White* AGE AT LAST BIRTHDAY *19* (Years)BIRTHPLACE *Idaho*OCCUPATION *Housewife*Number of children of this mother now living, including present birth, *None*

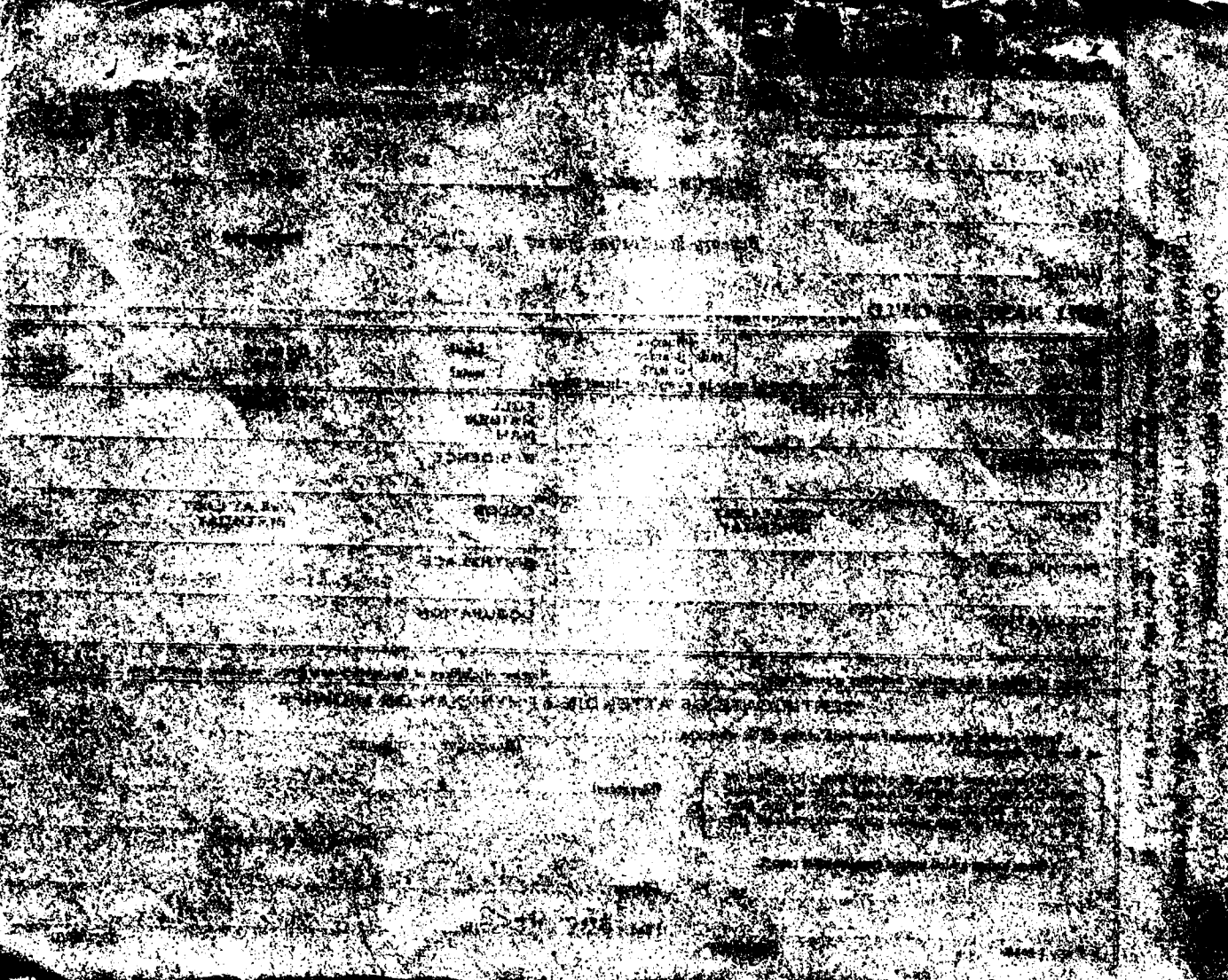
## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ on the date above stated.

{ \*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

Given names added from a supplemental report.

(Signature) *Stillborn* at *12:30 A.M.*  
(Born alive or stillborn)(Signature) *D. C. Weaver*  
Physician  
(Physician or midwife)Address *Twain Falls, Ida.*Filed *AUG 9-22* 19*22*  
*John F. Kousken*  
Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Lincoln Registration District No. 37  
 City of Rogerson Registration District No. 2085  
 State of Idaho (No. 151) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Jensen

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 39126

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single  
(Write the word.)

6. DATE OF BIRTH.

1 27 12  
 (Month) (Day) (Year)

7. AGE

2 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
 how many ..... hrs. or  
 ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Rogerson

10. NAME OF FATHER

G. E. Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Dora Willis

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

C. D. Mauer

15.

Filed

Aug - 9 - 1922

John H. Thompson  
 Local Registrar

16. DATE OF DEATH

7 27 1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~  
on 7/27 1922 to 191.....

that I last saw her alive on 191.....  
 and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH\* was as follows:

Unknown  
Still born

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed)

M. D.

19..... (Address) C. D. Mauer

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted  
 if not at place of death?.....

Former or  
 usual residence .....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rogerson - Ida1922

20. UNDERTAKER

ADDRESS

no  
Father (G. E. Jensen Rogerson)

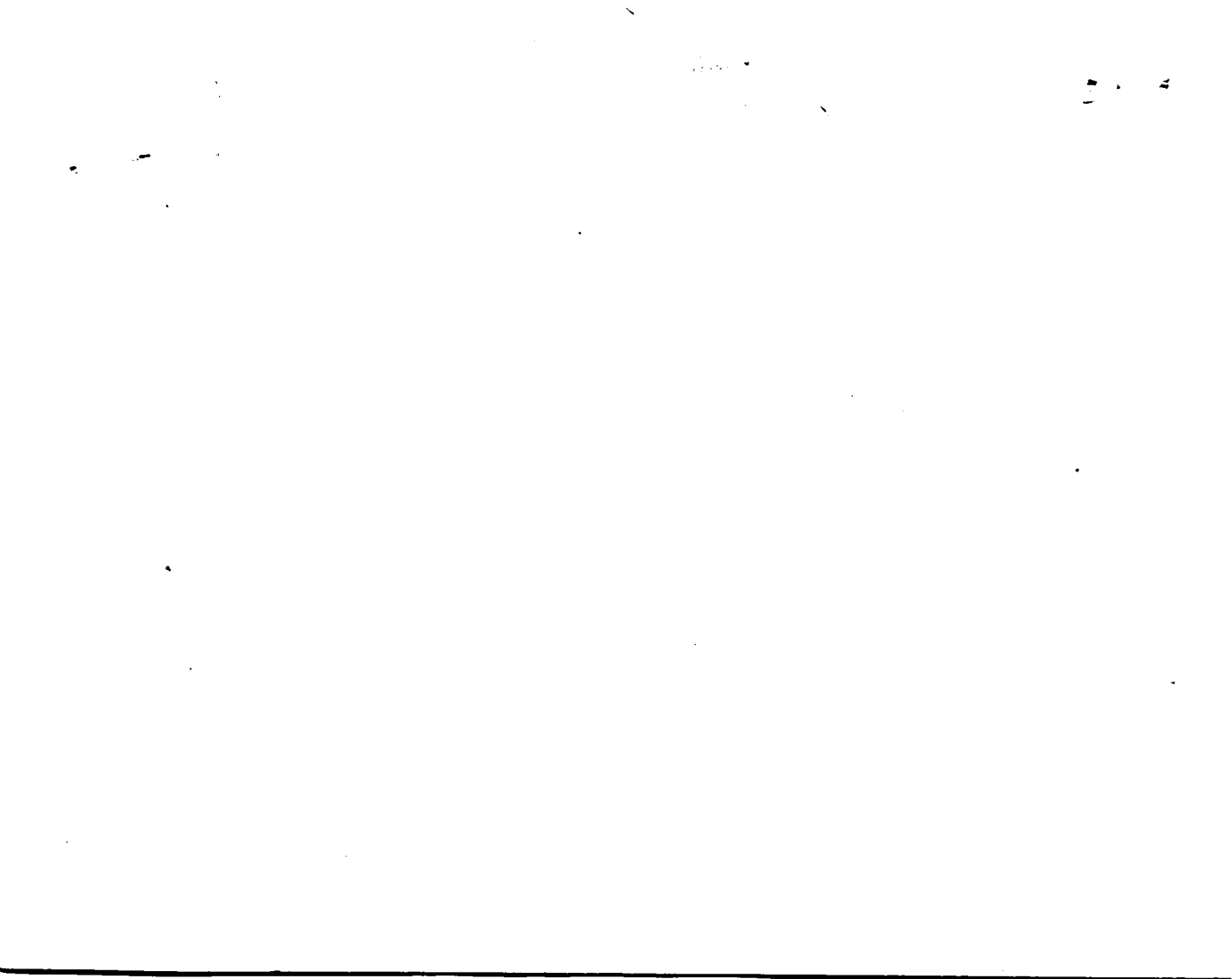
A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Registrar  
Ag No 317 Eyes -





WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED  
AUG 15 1922

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shwin Falls*

Registration District No. *37*

City of *Shwin Falls*

Primary Registration District No. *2085*

City of *Shwin Falls* St. No. *155* St.

File No. *39131*

Registered No. *1898*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

*Baby Dean*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*White*

*Single*  
(Write the word.)

6. DATE OF BIRTH

*July 29 1922*  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Shwin Falls, Ida.*

10. NAME OF FATHER

*Mark Dean*

11. BIRTHPLACE OF FATHER

(State or Country)

*Neb.*

12. MAIDEN NAME OF MOTHER

*Alma M. Wood.*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Iowa*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mark Dean*

(Address)

*Shwin Falls, Ida.*

15.

Filed *Aug 9 - 1922*

*John F. Houghton*  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*July 29 1922*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*July 29<sup>th</sup> 1922 to Aug 29 1922*  
that I last saw him *alive on Born dead* 1922  
and that death occurred on the date stated above, at *11:10* M.  
The CAUSE OF DEATH\* was as follows:

*Still born*

(Duration) Yrs. mos. ds.

Contributory *Premature*  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Samuel L. Alexander*

*7/30 1922* (Address) *Shwin Falls, Ida.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Shwin Falls July 31 1922*

20. UNDERTAKER

ADDRESS

*P. P. Grosman Shwin Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLA

S

S 104154

County of \_\_\_\_\_

City of \_\_\_\_\_

Registration District No. 37

File No. \_\_\_\_\_

No. 130 Walnut St.

STATISTICAL

1085

Primary Registration District No.

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <b>male</b>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth 4	Legiti mate? yes	Date of Birth 7 9 22 (Month) (Day) (Year)
-----------------------------	---	-----	-------------------------------------	------------------------	---

FATHER  
FULL NAME  
**Harry Severin**

RESIDENCE

130 Walnut St. Twin Falls, Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

32

(Years)

BIRTHPLACE

Colorado

OCCUPATION

runs gas and oil station

MOTHER  
FULL MAIDEN NAME  
**Martha Ostlund**

RESIDENCE

130 Walnut St. Twin Falls, Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

31

(Years)

BIRTHPLACE

Sweden

OCCUPATION

housewife

Number of child of this mother, including present birth 4      Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 11 A.M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

*Benjamin H. Rouse M.D.*  
Reg. No. 11218

(Physician or midwife)

Given names added from a supplemental report.

19.

Address

137 Third Ave. N. Twin Falls, Idaho

Filed

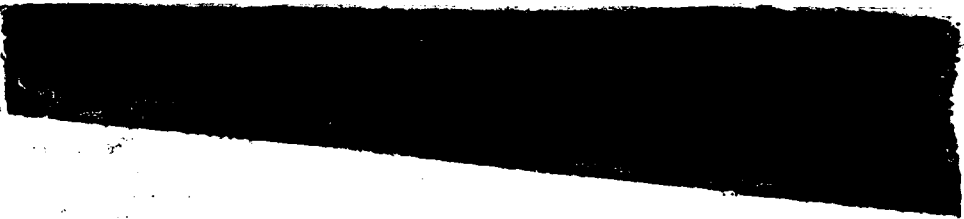
Aug. 9-22 19

Registrar

Registrar

*John F. Loughlin*  
Registrar

MARGIN RESERVED FOR BINDING.  
WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 12-12-2001 BY 60322  
UCBAW

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 39129

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of *San Falls* District No. *34*  
City of *San Falls* Primary Registration District No. *1085* St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

AUG 17 1922

*Infant Sererin*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male white Infant* (Write the word.)

## 6. DATE OF BIRTH

*July 9 1922*  
(Month) (Day) (Year)

## 7. AGE

*0 Yrs. 0 Mos. 0 ds.*  
IF LESS than 1 day how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

## 9. BIRTHPLACE

(State or Country) *Idaho*

## 10. NAME OF FATHER

*Henry Sererin*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Calo*

## 12. MAIDEN NAME OF MOTHER

*Martha Ostlund*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Sweeden*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry Sererin*(Address) *130 Walnut St.*

## 15.

Filed *9 10 1922* *John H. Coughlin*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*July 9 1922*  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *about Apr 1 1922* to *July 9 1922*that I last saw him *still born* *19*  
and that death occurred on the date stated above, at *11:00 AM*.

The CAUSE OF DEATH\* was as follows:

*strangled before birth*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Benjamin H. Rouse* M. D.*7-9 1922* (Address) *137-3rd Ave. N. Twin Falls*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*San Falls* *7-10 1922*

## 20. UNDERTAKER

*John H. Coughlin* *San Falls*

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**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

415-109-003-463  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Burnham REC-1  
City of Pocatello SEP 1  
No. 657 N. 6 ave St. BUREAU OF VITAL STATISTICS  
Registration District No. 28 File No. 81  
Hospital \_\_\_\_\_ Primary Registration District No. 2161 Registered No. 4523  
FULL NAME OF CHILD No Name —  
(Certificate of no value without full name of child.)

Sex of Child <u>M</u> —	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>8-9</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 3 ... Number of child of this mother now living, including present birth... 2 ...

FATHER		MOTHER	
FULL NAME	<u>C Marchetti</u>	FULL MAIDEN NAME	<u>Rettie Molinar</u>
RESIDENCE	<u>Pocatello</u>	RESIDENCE	<u>same</u>
COLOR	<u>w</u>	COLOR	<u>w</u>
AGE AT LAST BIRTHDAY	<u>35</u> (Years)	AGE AT LAST BIRTHDAY	<u>36</u> (Years)
BIRTHPLACE	<u>Italy</u>	BIRTHPLACE	<u>Italy</u>
OCCUPATION	<u>laborer</u>	OCCUPATION	<u>husb</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... dead ... at... 7:45/9 M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

(Physician or midwife)

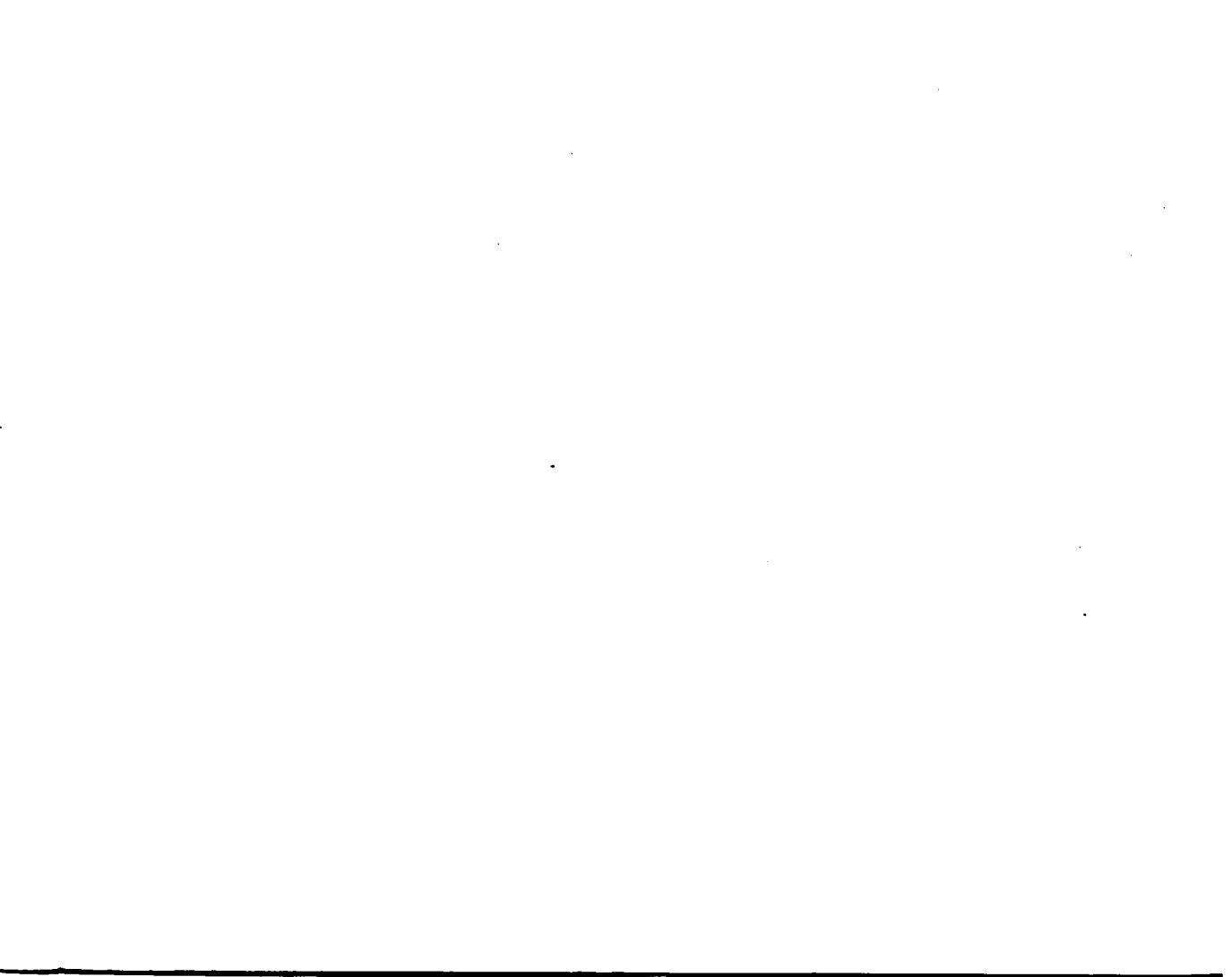
Give names added from a supplemental report.

Address \_\_\_\_\_

Filed \_\_\_\_\_

Registrar.

Registrar.





WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

269-2241003-217  
PLACE OF BIRTH

RECEIVED  
SEP 15 1922  
STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Pocatello, Idaho

No. 1744 Roosevelt St.

Registration District No. 28

File No. 104319

Hospital St. Anthony's

Primary Registration District No. 2161

Registered No. 4548

FULL NAME OF CHILD

Still Born

(Certificate of no value without full name of child.)

Sex of Child Female

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti-  
mate?

Yes

Date of  
birth

Aug. 24th

1922

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? no

Number of child of this mother, including present birth.....

Number of child of this mother now living, including present birth.....

FULL  
NAME

FATHER

Albert

Sorella

FULL  
MAIDEN  
NAME

MOTHER

Emma Saxton

RESIDENCE

1744 Roosevelt

RESIDENCE

1744 Roosevelt

COLOR

White

AGE AT LAST  
BIRTHDAY

19

(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

19

(Years)

BIRTHPLACE

n

Inkom, Idaho.

BIRTHPLACE

Pocatello, Idaho.

OCCUPATION

Farmer

OCCUPATION

Hawf.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was.....  
on the date above stated.

still born

at

4:00 P. M.

(Born alive or stillborn)

(Signature)

Dr. J. Howard, M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Pocatello, Idaho.

Filed

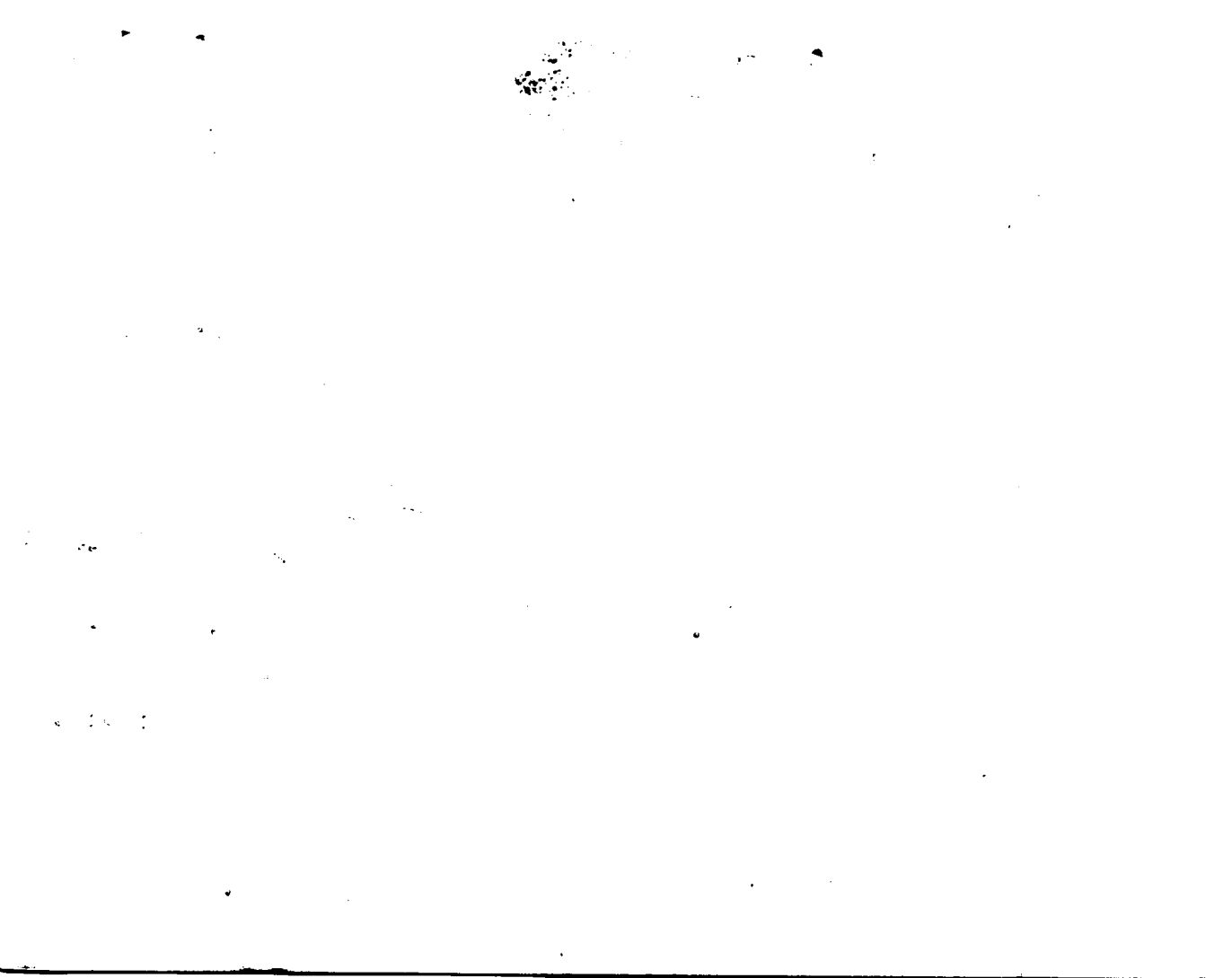
9-1

1922

Registrar.

Registrar.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. 3. No. 5-A—25 M. 1-19.

# CERTIFICATE OF DEATH

39218

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No.

County of

Primary Registration District No.

City of

(St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him ~~dead~~ ~~not~~ 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

8/25/1922 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

234-231-003-795  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bannock  
City of Pocatello  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 28 File No. 104324  
Hospital Local General Primary Registration District No. 2161 Registered No. 4553

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>8-31</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? 20.0% Argol

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>James Bernard Sturman</u>	FULL MAIDEN NAME	<u>Vella Preston</u>
RESIDENCE	<u>Bancroft, Idaho</u>	RESIDENCE	<u>Same</u>
COLOR	<u>Wht</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>21</u> (Years)	AGE AT LAST BIRTHDAY	<u>19</u> (Years)
BIRTHPLACE	<u>Lurkingham, Kansas</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Welder</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was dead at 12<sup>45</sup> 9 M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]

(Physician or midwife)

Give names added from a supplemental report.

Address Pocatello

Filed 9-1 1922

Registrar.

Registrar.

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250



ATTACH TO FORM

City of

STATE OF

County of

Section of

Range of

Township of

County of

State of

Section of

Range of

Township of

County of

State of

Section of

Range of

Township of

County of

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

89217  
28  
2161

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 53

1. PLACE OF DEATH

County of *Bannock*

City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

2. FULL NAME

*Infant Sturman*

Registered No. 3902

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

*Female white*

(Write the word.)

6. DATE OF BIRTH

*Aug 31 - 1922*

7. AGE

*210*

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*James Sturman*

11. BIRTHPLACE OF FATHER

(State or Country)

*Kansas*

12. MAIDEN NAME OF MOTHER

*Vella Preston*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*James Sturman*  
*Bancroft Idaho*

15.

Filed *8/31* 1922

*J. P. Young*  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Aug 31* 19*22*

17. I HEREBY CERTIFY That I attended deceased from

*Stillborn Aug 31 1922*

that I last saw him *live on Aug 31 1922*

and that death occurred on the date stated above, at *12 A.M.*

The CAUSE OF DEATH\* was as follows:

*Stillborn*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

*8/31/22* (Address) *Mountain View, Idaho*  
\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mountain View*

*Sept 1 1922*

20. UNDERTAKER

ADDRESS

*Schumacher & Co* *Pocatello*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



632-223-003-154

## PLACE OF BIRTH

County of BannockCity of Orford

No. ....St.

Hospital .....

## FULL NAME OF CHILD

Sex of Child

7Twin  
Triplet  
or other?and (Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti-  
mate?YesDate of  
Birth7-23

(Month) (Day) (Year)

FULL  
NAMEAugust Olson

RESIDENCE

Orford, Ida.

COLOR

WAGE AT LAST  
BIRTHDAY35

(Years)

BIRTHPLACE

Orford

OCCUPATION

FarmerFULL  
MAIDEN  
NAMEChristiana Anderson

RESIDENCE

Orford

COLOR

WAGE AT LAST  
BIRTHDAY35

(Years)

BIRTHPLACE

Sweden

OCCUPATION

HousewifeNumber of child of this mother, including present birth 3Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 7 P.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. H. Hartman

(Physician or midwife)

Given names added from a supplemental report.

Address

Orford, Ida.

Filed

7-24-22

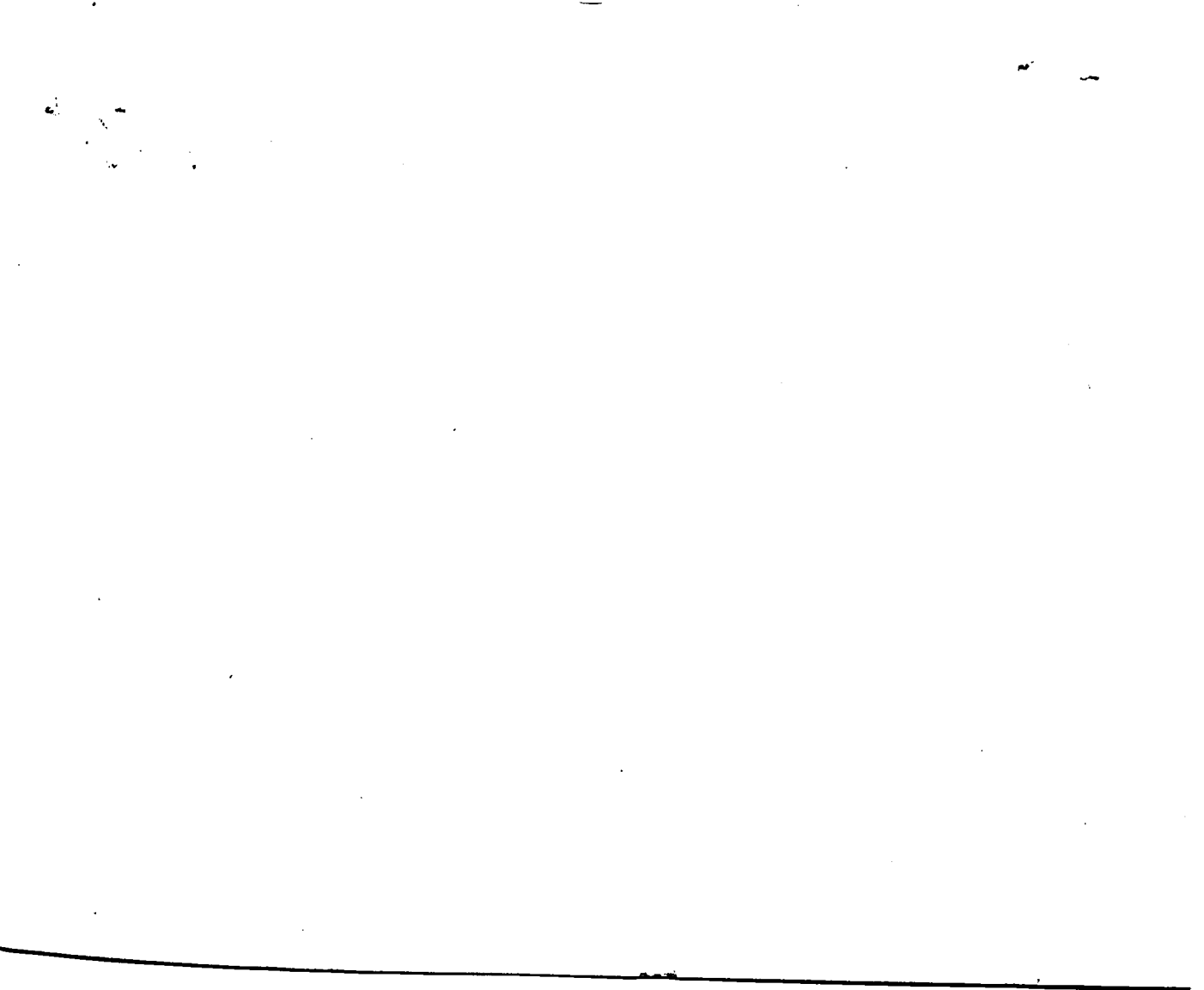
Registrar

Registrar

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25a-8-8-17

S104335



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. **39197**  
Registered No. \_\_\_\_\_

## 1. PLACE OF DEATH

County of Bannock Registration District No. 83  
City of Orford Registration District No. 2160 St. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

Apr. 23, 1922  
(Month) (Day) (Year)

## 7. AGE

Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds. \_\_\_\_\_

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) Orford, Ida.

## 10. NAME OF FATHER

O. Angus Olson

## 11. BIRTHPLACE OF FATHER

(State or Country) Orford

## 12. MAIDEN NAME OF MOTHER

Kristina Anderson

## 13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Angus Olson(Address) Orford Ida

## 15.

Filed 4-23-1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

April 23, 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19. \_\_\_\_\_, to 19. \_\_\_\_\_

that I last saw him alive on 19. \_\_\_\_\_

and that death occurred on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH\* was as follows:

Stillbirth

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. H. Hentrich M. D.4-23-1922(Address) Lawrence, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Orford Ida. Apr. 24, 1922.

## 20. UNDERTAKER

## ADDRESS

W. M. Boyer

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

937-224  
PLACE

OF IDAHO  
OF PUBLIC WELFARE  
VITAL STATISTICS

County of Boone **BUREAU OF VITAL STATISTICS**  
City of Cleveland **CERTIFICATE OF BIRTH**  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 211983 File No. 104340  
Hospital \_\_\_\_\_ Primary Registration District No. 27260 Registered No. \_\_\_\_\_

**FULL NAME OF CHILD** \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>girl</u>	Twin Triplet or other? _____ } and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>June 24</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 2 ... Number of child of this mother now living, including present birth... 0 ...

FATHER		MOTHER	
FULL NAME	<u>Charles M<sup>c</sup> Greger</u>	FULL MAIDEN NAME	<u>Merma Richardson</u>
RESIDENCE	<u>Cleveland Ota.</u>	RESIDENCE	<u>Cleveland Ida.</u>
COLOR	<u>W</u>	COLOR	<u>W</u>
AGE AT LAST BIRTHDAY	<u>30</u> (Years)	AGE AT LAST BIRTHDAY	<u>25</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Farming</u>	OCCUPATION	<u>Housewife</u>

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\***

I hereby certify that I attended the birth of this child, who was stillborn at 4:15 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) G. R. Culler

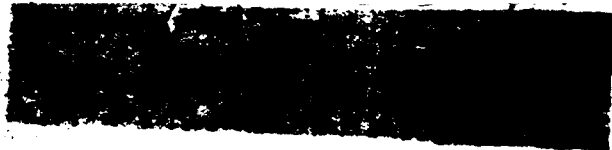
(Physician or midwife)

• Give names added from a supplemental report.

Address Preston Idaho

Filed 7-10-1922 H. H. Hartigson Registrar.

Registrar.



57

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

## 1. PLACE OF DEATH

County of Barnock  
City of Cleveland

If death occurs away from usual residence, give facts called for under special information.

## RECEIVED CERTIFICATE OF DEATH

Registration District No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_  
City of \_\_\_\_\_ St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 39198  
Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

Stillborn

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

F.

## 4. COLOR OR RACE

white

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single  
(Write the word.)

## 6. DATE OF BIRTH

June 24 1922  
(Month) (Day) (Year)

## 7. AGE

Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds. \_\_\_\_\_

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

## 9. BIRTHPLACE

(State or Country)

Cleveland Ida.

## 10. NAME OF FATHER

Charles M<sup>c</sup>Gugger

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Merna Richardson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed August 22 H. J. Hartvigsen  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

June 24 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19\_\_\_\_ to 19\_\_\_\_  
that I last saw her alive on 19\_\_\_\_  
and that death occurred on the date stated above, at 4 15 P.M.

The CAUSE OF DEATH\* was as follows:

Elk pneumonia mother

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

A. R. Cutler

M. D.

6-24-1922 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Cleveland Ida. June 25 1922

## 20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

355 127-006-639  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
**CERTIFICATE OF BIRTH**

**S**

County of Bingham  
City of Blackfoot  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 121 File No. 104459  
Hospital \_\_\_\_\_ Primary Registration District No. 1007 Registered No. 382

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Lenon

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Sept 27</u> 192 <u>7</u> (Month) (Day) (Year)
What bacteriocidal solution was used in eyes? <u>None</u>					
Number of child of this mother, including present birth <u>8</u>			Number of child of this mother now living, including present birth <u>7</u>		
FATHER FULL NAME <u>Oscar Lenon</u>			MOTHER FULL MAIDEN NAME <u>Mary Oliver</u>		
RESIDENCE <u>Blackfoot</u>			RESIDENCE <u>Blackfoot</u>		
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>48</u> (Years)		COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>41</u> (Years)	
BIRTHPLACE <u>Missouri</u>			BIRTHPLACE <u>Illinois</u>		
OCCUPATION <u>Farming</u>			OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... Stillborn at 10 9 M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

W. W. Beck

(Physician or midwife)

Give names added from a supplemental report.

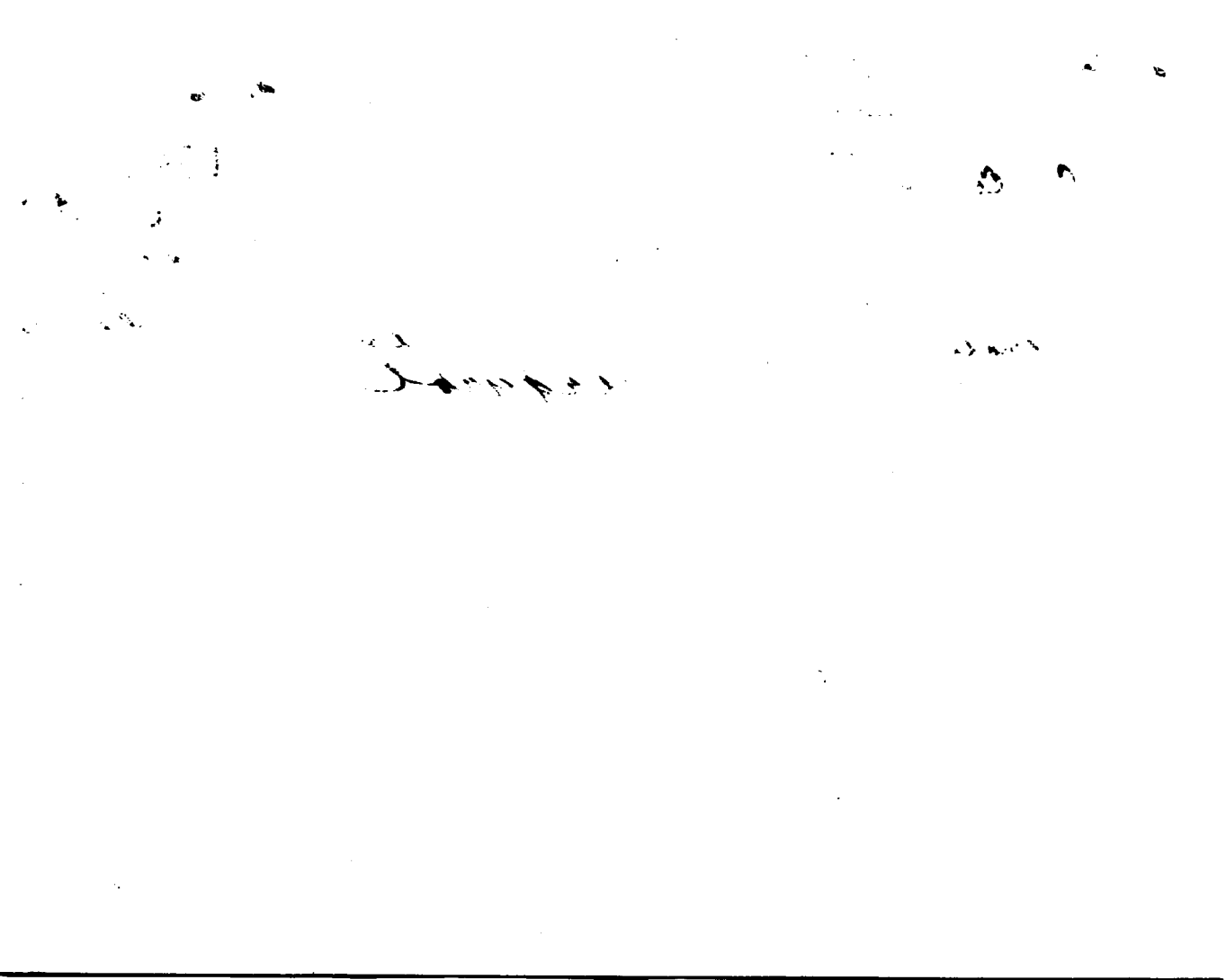
Address

Blackfoot, Idaho  
Oct. 4 1927 Mrs. Halsey E. Talbot

Filed

Registrar.

Registrar.



## 1. PLACE OF DEATH

County of Bingham Registration District No. 121  
 City of Blackfoot Primary Registration District No. 1007 St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Lenon

## CERTIFICATE OF DEATH

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 39249  
 Registered No. 143

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED

Male White Single  
 (Write the word.)

6. DATE OF BIRTH

Sept 27 1922  
 (Month) (Day) (Year)

7. AGE

Stillborn  
 Yrs. mos. ds. IF LESS than 1 day  
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Oscar Lenon

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Mary Oliver

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Oscar Lenon  
Blackfoot Ida

15.

Filed

Sept. 27 1922 Mo. Hales E. Palmer  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn Sept 27 1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 27 1922 to Sept 27 1922  
 that I last saw him alive on Was Stillborn  
 and that death occurred on the date stated above, at 102M.

The CAUSE OF DEATH\* was as follows:

Premature Detachment of  
placenta

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Beck M. D.

9/27/22 (Address) Blackfoot Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot 19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

388-103-006-632  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bingham Oct 6 1922  
City of Blackfoot BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 121 File No. 104469  
Hospital \_\_\_\_\_ Primary Registration District No. 2194 Registered No. 392

FULL NAME OF CHILD William Christianse  
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin- Fetiot or other?	and	Number in order of birth <u>1st</u>	Legiti- mate? <u>yes</u>	Date of birth <u>9/3</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacterioidal solution was used in eyes? X

Number of child of this mother, including present birth... 6 ... Number of child of this mother now living, including present birth... 5 ...

FATHER		MOTHER	
FULL NAME	<u>William Christianse</u>	FULL MAIDEN NAME	<u>Sophia Olson</u>
RESIDENCE	<u>Blackfoot</u>	RESIDENCE	<u>Blackfoot</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>38</u> (Years)	AGE AT LAST BIRTHDAY	<u>36</u> (Years)
BIRTHPLACE	<u>Hyrum Utah</u>	BIRTHPLACE	<u>Hyrum Utah</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 10 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. O. Hampton M.D.  
(Physician or midwife)

Give names added from a supplemental report.

Address Blackfoot, Id.  
Filed Oct 6 1922 Mrs. Hales E. J. Olmsted  
Registrar.

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

104442

Registration District No. 5121

Registered No. 301

Full name of child at birth: [illegible]  
Date of birth: [illegible]  
Place of birth: [illegible]

FULL NAME	[illegible]
RESIDENCE	[illegible]
COLOR	[illegible]
AGE AT LAST BIRTHDAY	[illegible]
BIRTHPLACE	[illegible]
OCCUPATION	[illegible]

Signature of attending physician: [illegible]  
Date of birth: [illegible]

Address: [illegible]  
City: [illegible]  
State: [illegible]

DECEASED  
TAKEN  
A  
GIRL  
MAY 1911  
IN  
NEW YORK  
CITY  
BUREAU OF VITAL STATISTICS  
NEW YORK CITY

## 1. PLACE OF DEATH

County of Bingham Registration District No. 131  
 City of Blackfoot Primary Registration District No. 2194  
 (State) \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Bob C. Unnamed Christensen

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 39245  
Registered No. 139

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Boy | white | Single  
(Write the word.)

## 6. DATE OF BIRTH

Sept 3 1922  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

none

## 9. BIRTHPLACE

(State or Country)

Idaho  
Bingham

## 10. NAME OF FATHER

Tom Christensen

## 11. BIRTHPLACE OF FATHER

(State or Country)

Utah

## 12. MAIDEN NAME OF MOTHER

Sophia Olson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr Christensen

(Address)

Blackfoot 2 RFD

## 15.

Filed Sept 3 1922 Mr. Walter E. Paul  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sept 3 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Sept 2 1922 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH\* was as follows:

still born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. O. Hampton M. D.

9/3 1922 (Address) Blackfoot Idw

\*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Thomas Russell 1922

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

168-227-008-599  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE •  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

104534

County of Bonner DEC 6 1922  
City of Sandpoint  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 78 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2155 Registered No. \_\_\_\_\_  
FULL NAME OF CHILD stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>    </u> } and { Number in order of birth <u>    </u>	Legitimate? <u>yes</u>	Date of birth <u>9/27/22</u> 192 <u>    </u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? 9

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FULL NAME <u>FATHER</u> <u>Henry Johnson</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Louise Brickson</u>
RESIDENCE <u>Sandpoint</u>	RESIDENCE <u>Sandpoint</u>
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>34</u> (Years)
BIRTHPLACE <u>Sweden</u>	BIRTHPLACE <u>Finland</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Haw.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

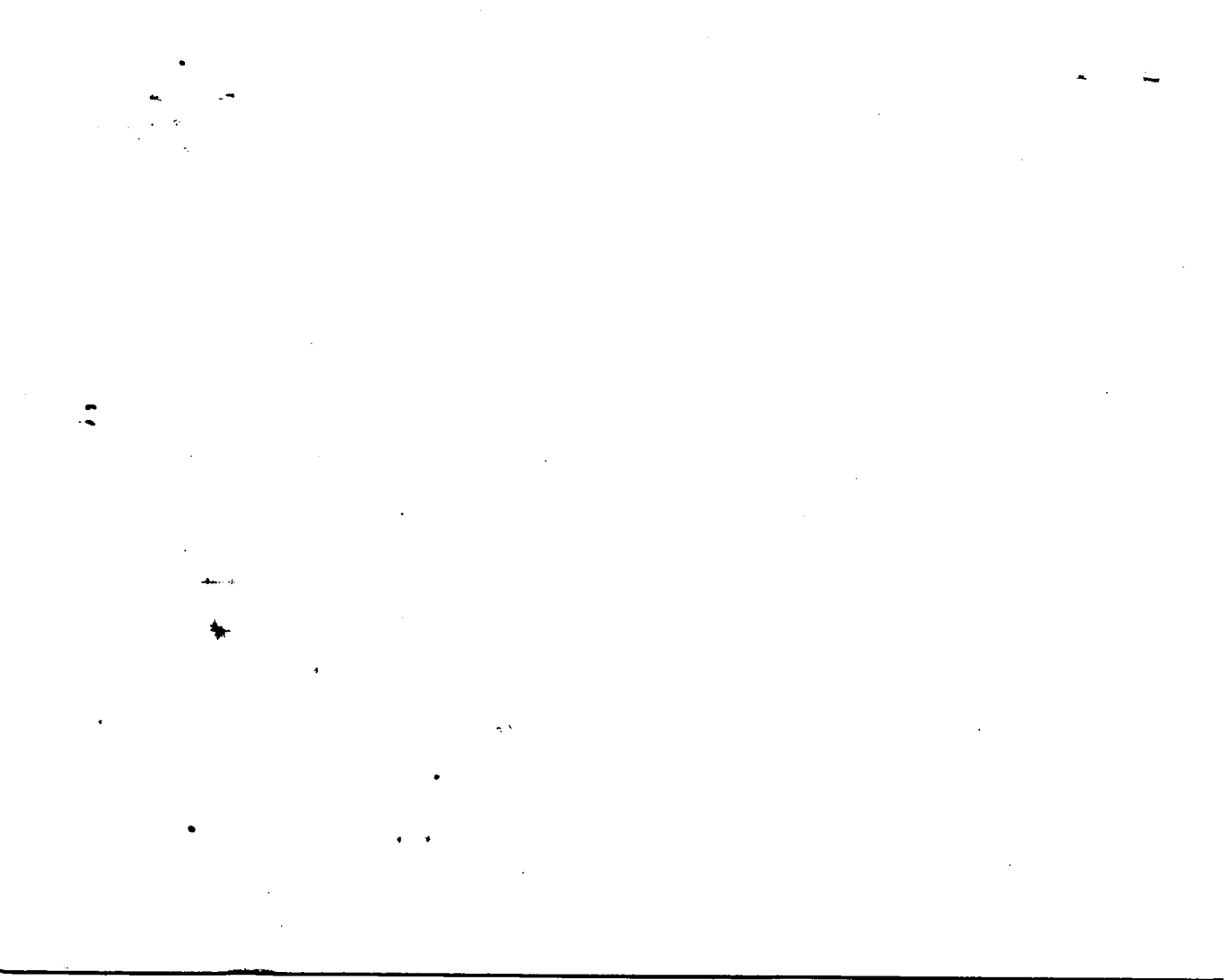
I hereby certify that I attended the birth of this child, who was stillborn at 6 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. R. W. Valentine  
M.D.  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Sandpoint  
Filed Oct 2 1922 Viola Allen  
Deputy Registrar.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of **Bonner**City of **Sandpoint**Registration District No. **76**Primary Registration District No. **2155**

(No. \_\_\_\_\_)

St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**stillborn**File No. **39565**

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

**female**

## 4. COLOR OR RACE

**white**

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

**single**

(Write the word.)

## 6. DATE OF BIRTH

**9/27/22**

(Month)

(Day)

1 (Year)

## 7. AGE

**stillborn**IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min. ?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

**Idaho**

## 10. NAME OF FATHER

**Henry Johnson**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Sweden**

## 12. MAIDEN NAME OF MOTHER

**Louise Erickson**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Finland**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

**Oct 2****1922**

Local Registrar

**Viola Allen**  
**Deputy**

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**9/27/22**

(Month)

(Day)

19 (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

**Stillborn**

19

to

19

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

**prematurity**

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

**M. R. Allen**

M. D.

**10/2/22**(Address) **Sandpoint Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Lakeview Cemetery****Sept 28 1922**

## 20. UNDERTAKER

## ADDRESS

**Father****Sandpoint, Idaho**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

257-226-014-869

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED BUREAU OF VITAL STATISTICS

County of Lamar SEP 13 1922 CERTIFICATE OF BIRTHCity of Houston BUREAU OF VITAL STATISTICS  
Registration District No. 3 File No. 104576No. R.F.D.#1 St.Primary Registration District No. 2005 Registered No. 174

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>Aug. 26</u> <u>1922</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	----------------------------	--

FULL NAME <u>John W. Seger</u>	FATHER
RESIDENCE <u>Houston</u>	

FULL MAIDEN NAME <u>Maisy Delila Harace</u>	MOTHER
RESIDENCE <u>Houston</u>	

COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
-----------------------	--

COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>18</u> (Years)
-----------------------	--

BIRTHPLACE <u>Okley, Minnesota</u>
---------------------------------------

BIRTHPLACE <u>Notus, Idaho</u>
-----------------------------------

OCCUPATION <u>Farmer</u>
-----------------------------

OCCUPATION <u>Housewife</u>
--------------------------------

Number of child of this mother, including present birth <u>1</u>	Number of children of this mother now living, including present birth <u>0</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 11:58 P.M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

19

(Signature) Dr. C. R. Whittenberger  
(Physician or midwife)

Address Caldwell, Idaho.

Filed Aug. 30, 1922 John V. Meyer  
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

100-100000-100000

100-100000-100000



100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

451-217-018-195

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of *Clearwater*

SEP 19 1922

CERTIFICATE OF BIRTH

S

City of *Oradell*

Registration District No. *90*

File No. *104653*

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. *2168*

Registered No. *58*

Hospital \_\_\_\_\_

FULL NAME OF CHILD

*Unnamed*

Sex of Child *Female*

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and { Number  
in order  
of birth  
(To be answered only in event of plural births)

Legitimate? *yes*

Date of Birth *Aug 17* 19*22*  
(Month) (Day) (Year)

FATHER  
FULL NAME *Lawrence Meeker*

RESIDENCE *Pierce Ida*

COLOR *White* AGE AT LAST BIRTHDAY *24* (Years)

BIRTHPLACE *Mich*

OCCUPATION *Farmer*

MOTHER  
FULL MAIDEN NAME *Lyne E. Arnold*

RESIDENCE *Pierce Ida*

COLOR *White* AGE AT LAST BIRTHDAY *24* (Years)

BIRTHPLACE *P. I.*

OCCUPATION *Housewife*

Number of child of this mother, including present birth \_\_\_\_\_ Number of children of this mother now living, including present birth *0*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Still born*, at *8:30 P.M.*  
on the date above stated. (Born ~~alive~~ stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *J. M. Fairly*  
*Physician*  
(Physician or midwife)

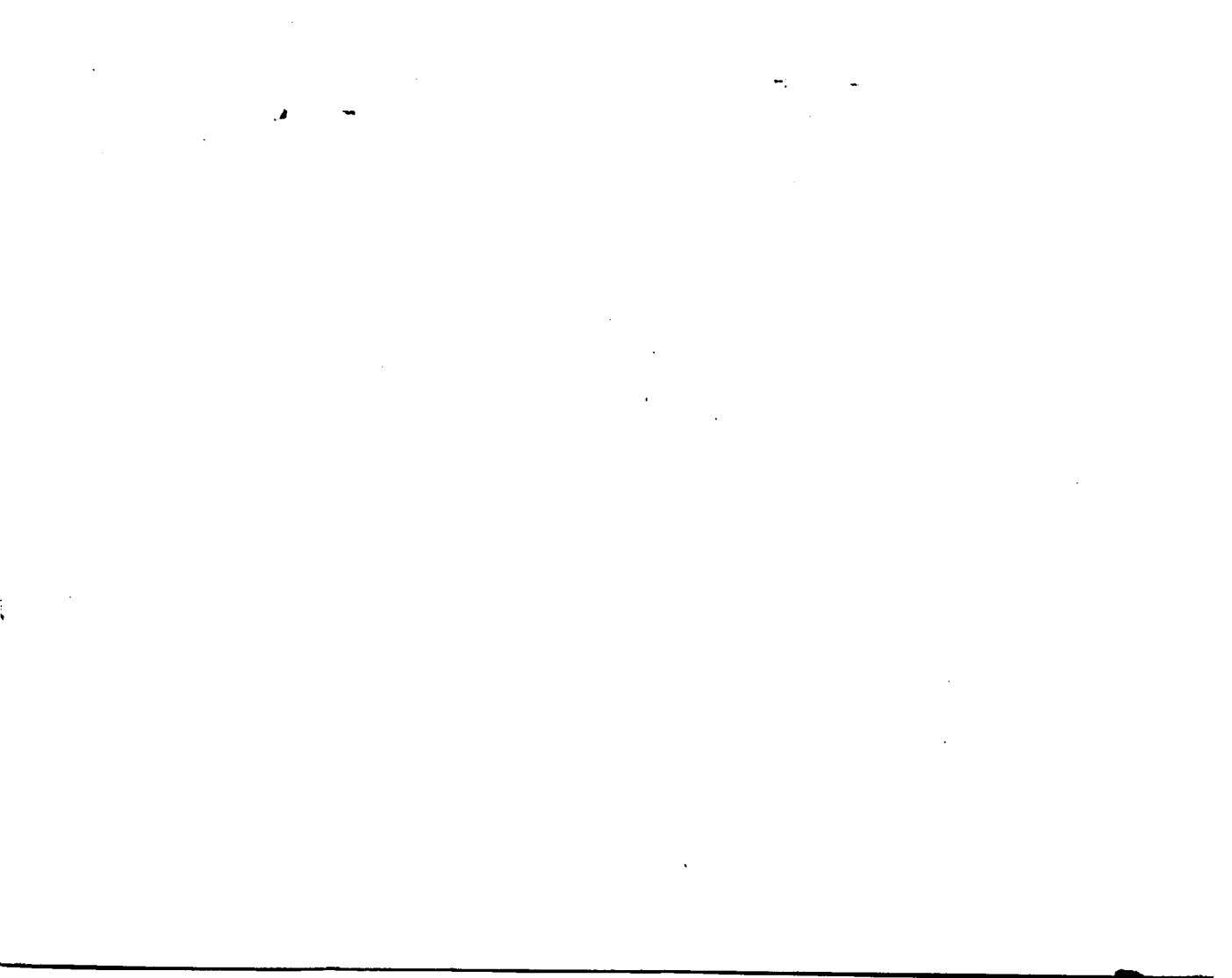
Given names added from a supplemental report.

Address *Oradell Idaho*

Filed *Aug 18* 19*22* *J. M. Fairly*  
Registrar

Registrar

Registrar





## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

RECEIVED

Registration District No.

Primary Registration District No.

No.

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

## 6. DATE OF BIRTH

## 7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1922 to Aug 17 1922

that I last saw h. — alive on — 1922 and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH\* was as follows:

Prolonged presentation - Delayed after coming head

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

8/17/1922

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

155-101-022-293  
PLACE OF BIRTH

RECEIVED

SEP 21 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

104749

County of Trinity

City of St Anthony

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

Registration District No. 99

File No. \_\_\_\_\_

Primary Registration District No. 2177

Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>6 1</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	---	-----------	--------------------------------	------------------------	---

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth. 2 Number of child of this mother now living, including present birth. none

FATHER  
FULL NAME Carl Jensen  
RESIDENCE St Anthony Colo  
COLOR white AGE AT LAST BIRTHDAY 44 (Years)  
BIRTHPLACE Utah  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Leah Olsen  
RESIDENCE St Anthony  
COLOR white AGE AT LAST BIRTHDAY 26 (Years)  
BIRTHPLACE Utah  
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

(Physician or midwife)

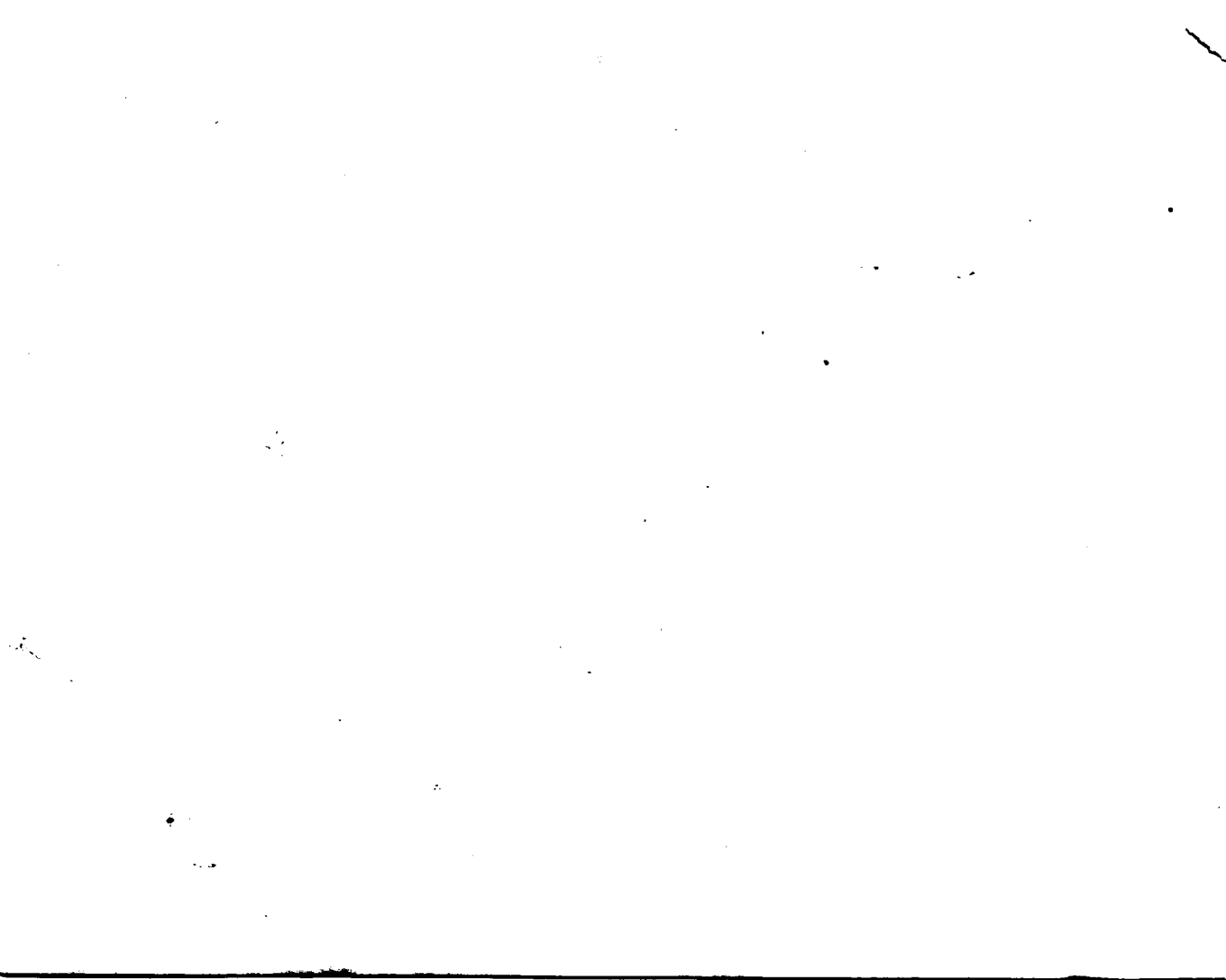
Give names added from a supplemental report.

Address \_\_\_\_\_

Filed 1 11 1922

Registrar.

Registrar.



AGE OF BIRTH 1466-127-026-533

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

RECEIVED

SEP 25 1922

CERTIFICATE OF BIRTH

104801

City of Payson No. 98 St. Payson File No. 240  
Hospital home Primary Registration District No. 2176 Registered No. 240

FULL NAME OF CHILD

Stillborn 7 mo.

(Certificate of no value without full name of child.)

Sex of Child <u>m</u>	Twin Triplet or other? <u>no</u>	and {	Number (in order of birth) <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>6/27</u> 1922 (Month) (Day) (Year)
-----------------------	----------------------------------	-------	-------------------------------------	------------------------	--

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth. 1 Number of children of the mother now living, including present birth. 1

FATHER		MOTHER	
FULL NAME <u>Lesley A Moore</u>	FULL MAIDEN NAME <u>Liza Elliott</u>	FULL NAME <u>Lesley A Moore</u>	FULL MAIDEN NAME <u>Liza Elliott</u>
RESIDENCE <u>Payson Ida</u>	RESIDENCE <u>Payson Ida</u>	RESIDENCE <u>Payson Ida</u>	RESIDENCE <u>Payson Ida</u>
COLOR <u>White</u>	COLOR <u>White</u>	COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>26</u> (Years)	AGE AT LAST BIRTHDAY <u>25</u> (Years)	AGE AT LAST BIRTHDAY <u>26</u> (Years)	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Nebraska</u>	BIRTHPLACE <u>Iowa</u>	BIRTHPLACE <u>Nebraska</u>	BIRTHPLACE <u>Iowa</u>
OCCUPATION <u>farmer</u>	OCCUPATION <u>hair</u>	OCCUPATION <u>farmer</u>	OCCUPATION <u>hair</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 10 P M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. C. Call M.D.

(Physician or midwife) Payson Ida.

Give names added from a supplemental report.

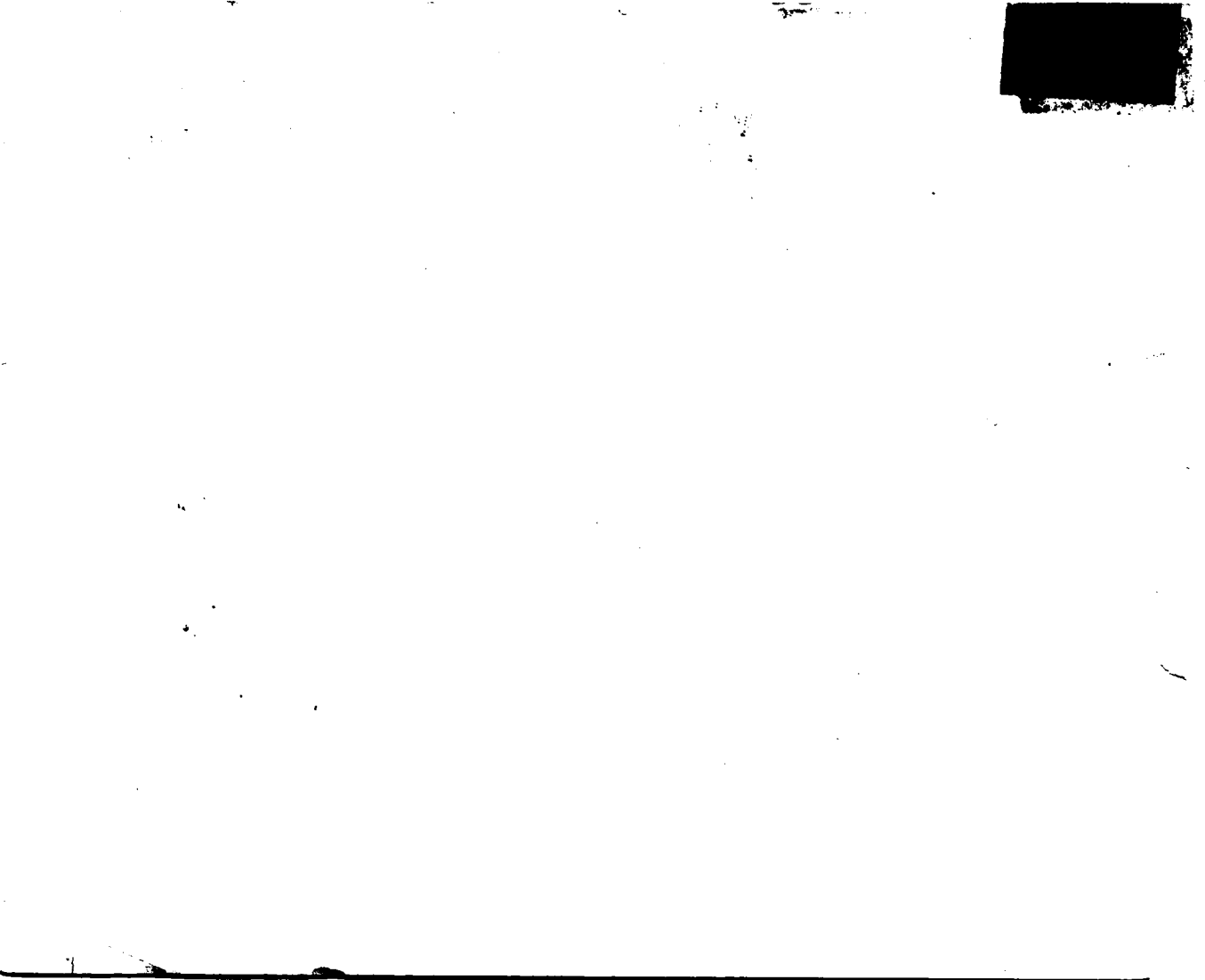
Address Payson Ida.

Filed 9-10 1922 Ray H. Fisher

Registrar.

Registrar.

...Y WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

## PLACE OF DEATH

County of Ada  
City of Boise

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

**S** 104812  
State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1004Local Registrar's No. 192

(No. \_\_\_\_\_)  
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Grandell, Emory Hale (Stillborn)(a) Residence. No. St. Luke's Hospital Boise St. \_\_\_\_\_(Usual place of abode) Boise Id (If nonresident give city or town and state)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. Color or Race White 5. Single, Married, Widowed or Divorced (write the word) Infant

5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE Years Months Days If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (mo. and yr.) None  
11. Total time (years) spent in this occupation None

12. BIRTHPLACE (city or town) Boise Idaho  
(State or country)MOTHER FATHER 13. NAME Robert H Grandell14. BIRTHPLACE (city or town) Longview  
(State or country)15. MAIDEN NAME Shady's Haddie16. BIRTHPLACE (city or town) Buzzell  
(State or country)17. INFORMANT R. H. Grandell  
(Address) Boise Id18. BURIAL, CREMATION OR REMOVAL  
Place Mereday Cemetery Date June 9, 193719. UNDERTAKER M. M. Matter  
(Address) Mereday20. FILED 6-9, 1937 R. Sharp  
Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day and year) 6-7-1937

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 193\_\_\_\_, to \_\_\_\_\_, 193\_\_\_\_

I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 193\_\_\_\_: death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Still Born -  
(Prolapsed Cord)

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 193\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and state)

Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_ If so, specify \_\_\_\_\_

(Signed) St. Lawrence, M. D.(Address) Boise Idaho

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who has no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry of business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employees," "worker," "operative," etc. Find out the particular kind of work done and return that as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**STATEMENT OF CAUSE OF DEATH.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## EXAMPLE I

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

Arteriosclerosis

1915

Chronic interstitial nephritis

1921

Cerebral hemorrhage

July 5, 1927

Other **CONTRIBUTORY CAUSES** of importance:

Gallstones

May 1, 1923

## EXAMPLE II

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

Attack of epilepsy

1 week ago

Run over by street car

1 week ago

Peritonitis

3 days ago

Other **CONTRIBUTORY CAUSES** of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN



692-210-026-453  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
RECEIVED  
BUREAU OF VITAL STATISTICS

S

County of Jefferson SEP 20 1922City of Rigby BUREAU OF VITAL STATISTICSRegistration District No. 98

File No.

104820

No. \_\_\_\_\_ St.

Primary Registration District No. 2176Registered No. 274

Hospital \_\_\_\_\_

## FULL NAME OF CHILD

Sex of Child <u>I</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and	Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>9-10-22</u> (Month) (Day) (Year)
FATHER			MOTHER		
FULL NAME <u>John E. Fisher</u>			FULL MAIDEN NAME <u>Coe Unck</u>		
RESIDENCE <u>Rigby</u>			RESIDENCE <u>Rigby</u>		
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>28</u> (Years)			COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>27</u> (Years)		
BIRTHPLACE <u>Utah</u>			BIRTHPLACE <u>Holland</u>		
OCCUPATION <u>Teacher</u>			OCCUPATION <u>at home</u>		
Number of child of this mother, including present birth <u>2</u>			Number of children of this mother now living, including present birth <u>2</u>		

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

stillborn 11 30 P. M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Ray Fisher

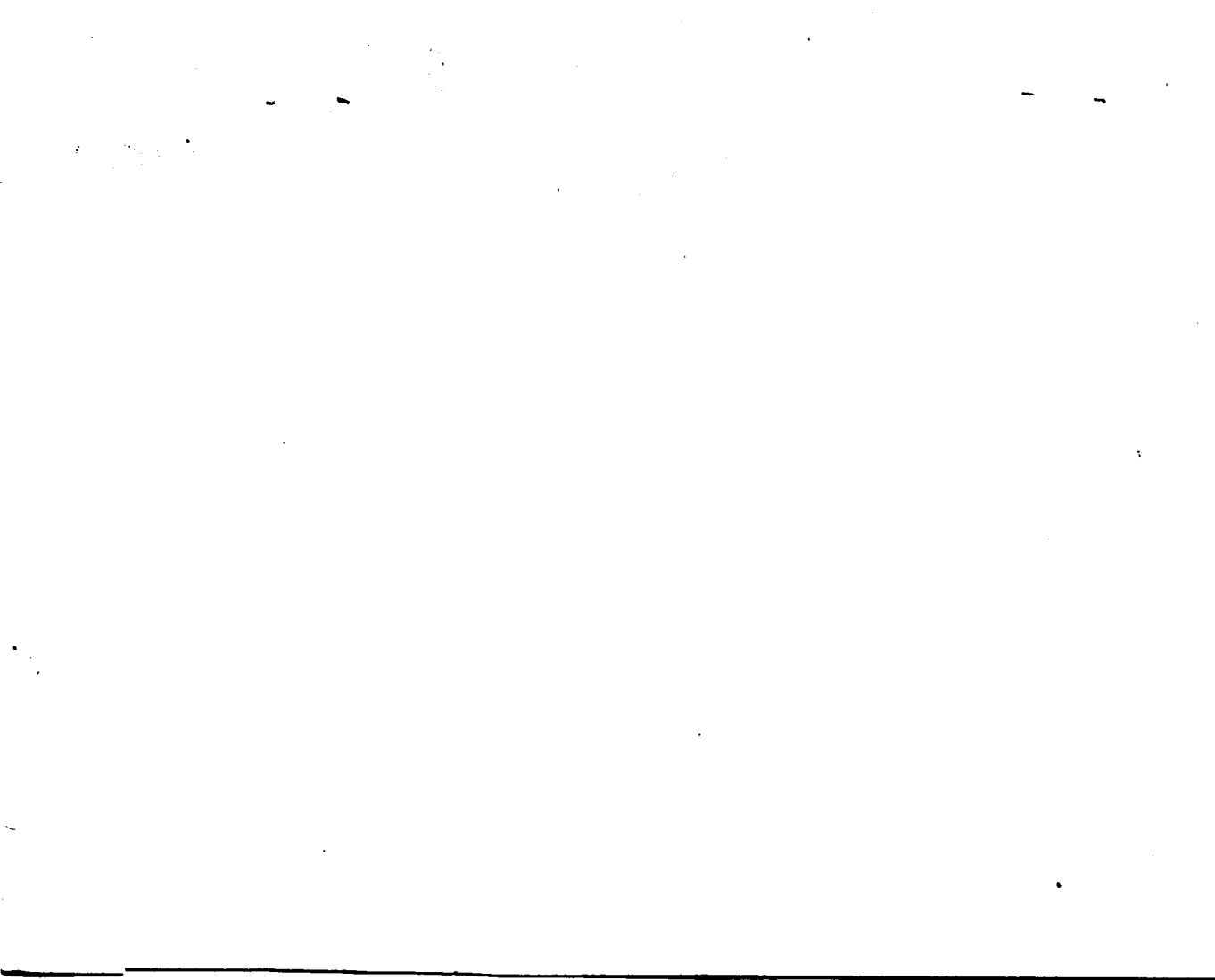
(Physician or midwife)

Given names added from a supplemental report.

Address RigbyFiled 9-10-22

Registrar.

Registrar.



FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

SEP 23 1922

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson Registration District No. 98  
 City of Highway Primary Registration District No. 2176  
 (No. \_\_\_\_\_) (St.) \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 39371  
 Registered No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED infant  
 (Write the word.)

6. DATE OF BIRTH

9 - 10 1922  
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John E Fisher

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Coe Unck

13. BIRTHPLACE OF MOTHER

(State or Country)

Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John E Fisher  
Highway Idaho

15.

Filled 9-10 1922 Ray H Fisher  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 - 10 1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....  
 that I last saw h..... alive on 19.....  
 and that death occurred on the date stated above, at..... M.  
 The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Ray H Fisher M. D.4-10-1922 Address Highway Idaho

\*State the Disease Causing Death; or in deaths from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

9-11 1922

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

689-131-026-515  
PLACE OF BIRTH

RECEIVED  
AUG 21 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11—20m-7-26-19

S

County of Jefferson  
City of Regley  
No. \_\_\_\_\_ St. \_\_\_\_\_

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH  
Registration District No. 98

File No. 104849

Hospital \_\_\_\_\_

Primary Registration District No. 2176 Registered No. 229

FULL NAME OF CHILD

Infant Whitman

Sex of Child

M

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legitimate?

yes

Date of Birth

7-31-22  
(Month) (Day) (Year)

(To be answered only in event of plural births)

FULL NAME

FATHER

John R. Whitman

FULL MAIDEN NAME

MOTHER

E. Anglessey

RESIDENCE

Regley

RESIDENCE

Regley

COLOR

w

AGE AT LAST BIRTHDAY

(Years)

COLOR

ws

AGE AT LAST BIRTHDAY

(Years)

BIRTHPLACE

Virginia

BIRTHPLACE

Utah

OCCUPATION

Farmer

OCCUPATION

at home

Number of child of this mother, including present birth \_\_\_\_\_ Number of children of this mother now living, including present birth \_\_\_\_\_

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M. on the date above stated.

stillborn  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Mary Smith

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

Aug 10 1922 Ray Fisher  
Registrar.

Registrar.

Registrar.

ORIGINAL FILED FOR INDEXING  
 THIS IS A COPY OF THE ORIGINAL FILED FOR INDEXING  
 IN CASE OF LOSS OF THE ORIGINAL FILED FOR INDEXING  
 THE ORIGINAL FILED FOR INDEXING

Form No. 1  
 STATE OF NEW YORK  
 DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS

No. 1234  
 Registration District No. 1234  
 Primary Registration District No. 1234  
 Registered No. 1234

HOSPITAL St. Mary's  
 FULL NAME OF CHILD John Doe

Sex of Child Male  
 (To be answered only in case of special birth)

Date of Birth 1912-12-25  
 Time of Birth 10:00 AM  
 Place of Birth St. Mary's Hospital

FATHER John Doe  
 MOTHER John Doe  
 Maiden Name John Doe  
 Residence John Doe

COLOR White  
 BIRTHPLACE New York  
 OCCUPATION None

AT LAST 1912-12-25  
 BIRTHPLACE New York  
 OCCUPATION None

Number of child of this mother, including present birth 1  
 Number of children of this mother now living, including present birth 1  
 CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive or stillborn  
 on the date above stated 1912-12-25  
 When born, was it still under division or born alive or stillborn  
 whether born the head, shoulders, etc. born alive or stillborn  
 should make this record. A stillborn child is born alive or stillborn  
 one that neither breathes nor shows other signs born alive or stillborn  
 of life after birth. born alive or stillborn

Given names added from a supplemental report John Doe  
 Address John Doe  
 Filed John Doe

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Idaho*  
City of *Boise*Registration District No. *98*Primary Registration District No. *2176*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Infant Mr & Mrs Whitman*State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *33034*Registered No. *48*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*M.*

## 4. COLOR OR RACE

*W.*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Bate.*  
(Write the word.)

## 6. DATE OF BIRTH

*7* (Month) *31* (Day) *1922* (Year)

## 7. AGE

*0* Yrs. *—* Mos. *—* ds.IF LESS than 1 day  
how many *—* hrs.  
or *—* min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).*Infant*

## 9. BIRTHPLACE

(State or Country)

*Boise Ida*

## 10. NAME OF FATHER

*John R Whitman*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Virginia*

## 12. MAIDEN NAME OF MOTHER

*E. Anglesy*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Mary L. Smith*  
*Boise*

## 15.

Filed

*Aug 10. 1922* *Ray H. Dick*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*7* (Month) *31* (Day) *1922* (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*81* 19 *20*, to 19 *—*that I last saw him alive on 19 *—*and that death occurred on the date stated above, at *—* M.

The CAUSE OF DEATH\* was as follows:

*Still born*(Duration) *—* Yrs. *—* mos. *—* ds.Contributory  
(Secondary)*Placenta cord.*(Duration) *—* yrs. *—* mos. *—* ds.

(Signed)

*Ray H. Dick*  
*Boise, Ida*19 *—* (Address)

\*State the Disease Causing Death; or in death from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *—* yrs. *—* mos. *—* days. In the State *—* yrs. *—* mos. *—* days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Boise, Ida.**Aug 1. 1922*

## 20. UNDERTAKER

## ADDRESS

*E. S. Sullivan**Boise*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

765-115625-279

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH  
County of Idaho RECEIVED SEP 13 1922 STATE OF IDAHO BUREAU OF VITAL STATISTICS  
City of Cottonwood BUREAU OF VITAL STATISTICS  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 105 File No. 56  
Hospital \_\_\_\_\_ Primary Registration District No. 2183 Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Sex of Child M. Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legiti mate? yes. Date of Birth Aug 15 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Frank Goeckner  
RESIDENCE Cottonwood  
COLOR W. AGE AT LAST BIRTHDAY 51  
(Years)  
BIRTHPLACE Ill.  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Gerisa Sprute  
RESIDENCE Cottonwood  
COLOR W. AGE AT LAST BIRTHDAY 42  
(Years)  
BIRTHPLACE Ill.  
OCCUPATION House wife

Number of child of this mother, including present birth 12 Number of children of this mother now living, including present birth 8

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 3 P. M.  
on the date above stated. (Born alive or stillborn)

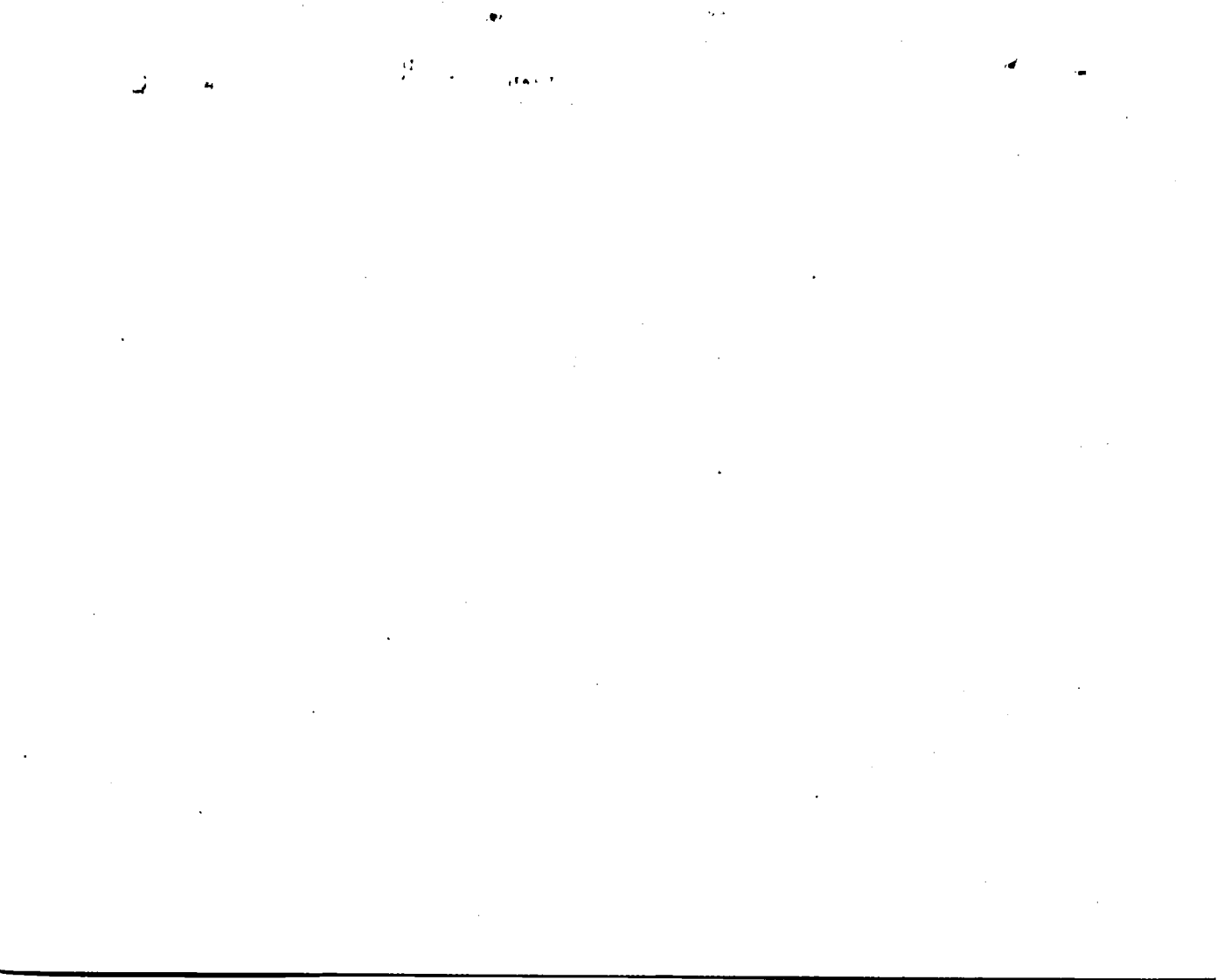
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. Wesley Orr  
(Physician or midwife)

Given names added from a supplemental report.

Address Cottonwood, Ill.  
Filed Aug 31 1922 W. F. Orr  
Registrar

Registrar



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED  
SEP 1 1922  
BUREAU OF VITAL STATISTICS

Registration District No. 105

Primary Registration District No. 2183

39363

File No. 18

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Aug 31 19 22

W. F. Orr  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 22  
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH was as follows:

Still birth due to Placenta  
Prævia

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wesley Orr M. D.

Aug 10 22 (Address) Cottonwood

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kinterville Id 8-17 19 22

20. UNDERTAKER

ADDRESS

J. H. Nau Cottonwood Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

445-113035-251  
PLACE OF BIRTH

RECEIVED

SEP 13 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Regina

City of Idaho Falls

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 26

File No. 106010

Hospital St. Joseph

Primary Registration District No. 1009

Registered No. 181

FULL NAME OF CHILD (unnamed)

(Certificate of no value without full name of child.)

Sex of  
Child

Male

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti-  
mate?

yes

Date of  
birth

Aug 13 1922  
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth. 1

Number of child of this mother now living, including present birth. 1

FULL  
NAME

FATHER

Ellis Ouney

FULL  
MAIDEN  
NAME

MOTHER

Bertha Beasley

RESIDENCE

Ardesac

RESIDENCE

Same

COLOR

W

AGE AT LAST  
BIRTHDAY

22  
(Years)

COLOR

W

AGE AT LAST  
BIRTHDAY

20  
(Years)

BIRTHPLACE

Colorado

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

Stillborn at 1:59 P. M.  
(Born Aug 13 1922)

\* When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

John B. Kelley

(Physician or midwife)

Give names added from a supplemental report.

Address

Idaho Falls, Ida.

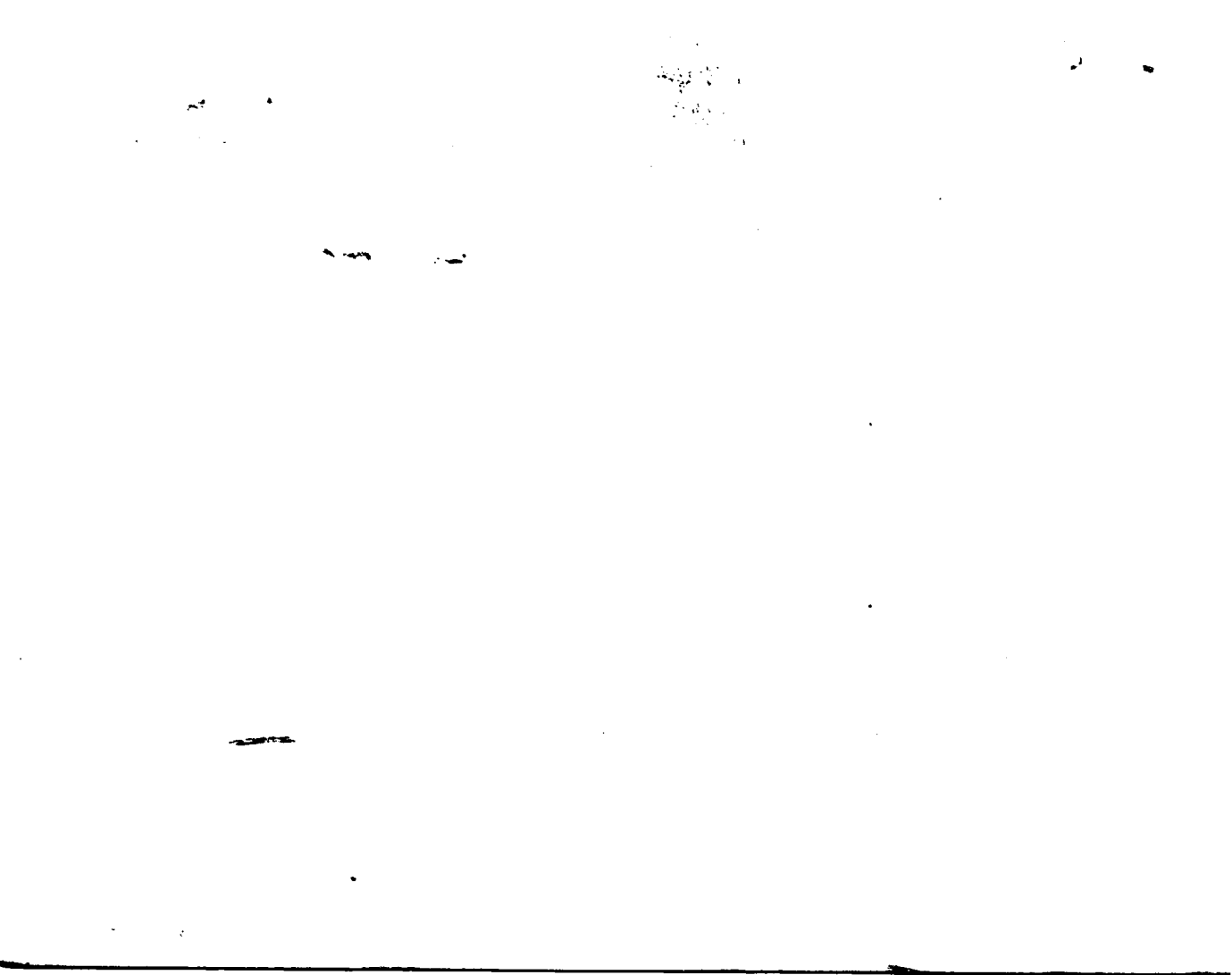
Filed

9/8/ 1922

F. T. Harris, M. D.

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

## 1. PLACE OF DEATH

County of *San Juan*City of *Leiston*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

SEP 13 1922

BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

Registration District No. *96*Primary Registration District No. *1009*(No. *1*)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *39415*  
Registered No. *147*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Lee Young Dunlop*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*4. COLOR OR RACE *White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH *Aug 13 1922*

(Month)

(Day)

(Year)

7. AGE *Stillborn*

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work *Infant*

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) *Idaho*10. NAME OF FATHER *Ellis Dunlop*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Colo*12. MAIDEN NAME OF MOTHER *Bertha Beasley*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ellis Dunlop*(Address) *Caldesar Idaho*

## 15.

Filed *9/8/1922*

F. T. Harris, M.D.  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 13 1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 13 1922* to *Aug 13 1922*that I last saw h. *alive* on *Aug 13 1922*and that death occurred on the date stated above, at *19* M.

The CAUSE OF DEATH\* was as follows:

*Still Born*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Ellis Dunlop*

19

(Address) *Caldesar Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Caldesar Idaho*DATE OF BURIAL *19*20. UNDERTAKER *Swinty*

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

132-117-035-613  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County Nezperce  
City of Leviaton

RECEIVED  
SEP 13 1922

CERTIFICATE OF BIRTH 105016

No. \_\_\_\_\_ St. \_\_\_\_\_  
Registration District No. 96 File No. \_\_\_\_\_  
Hospital St. Joseph's Primary Registration District No. 1009 Registered No. 187  
FULL NAME OF CHILD Edna Russell Atkinson  
(Certificate may also be made without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth. <u>Aug 17</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	---	------------------------------------	------------------------	---

What bactericidal solution was used in eyes? no.  
Number of child of this mother, including present birth. 9 Number of child of this mother now living, including present birth. 7

FATHER		MOTHER	
FULL NAME <u>Frank W. Atkinson</u>	FULL MAIDEN NAME <u>Ms. Catherine Walker</u>	FULL NAME <u>Frank W. Atkinson</u>	FULL MAIDEN NAME <u>Ms. Catherine Walker</u>
RESIDENCE <u>Charlotte</u>	RESIDENCE <u>same</u>	RESIDENCE <u>Charlotte</u>	RESIDENCE <u>same</u>
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE <u>Bularis, Canada</u>	BIRTHPLACE <u>Monte, Canada</u>	BIRTHPLACE <u>Bularis, Canada</u>	BIRTHPLACE <u>Monte, Canada</u>
OCCUPATION <u>Mail Carrier</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Mail Carrier</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

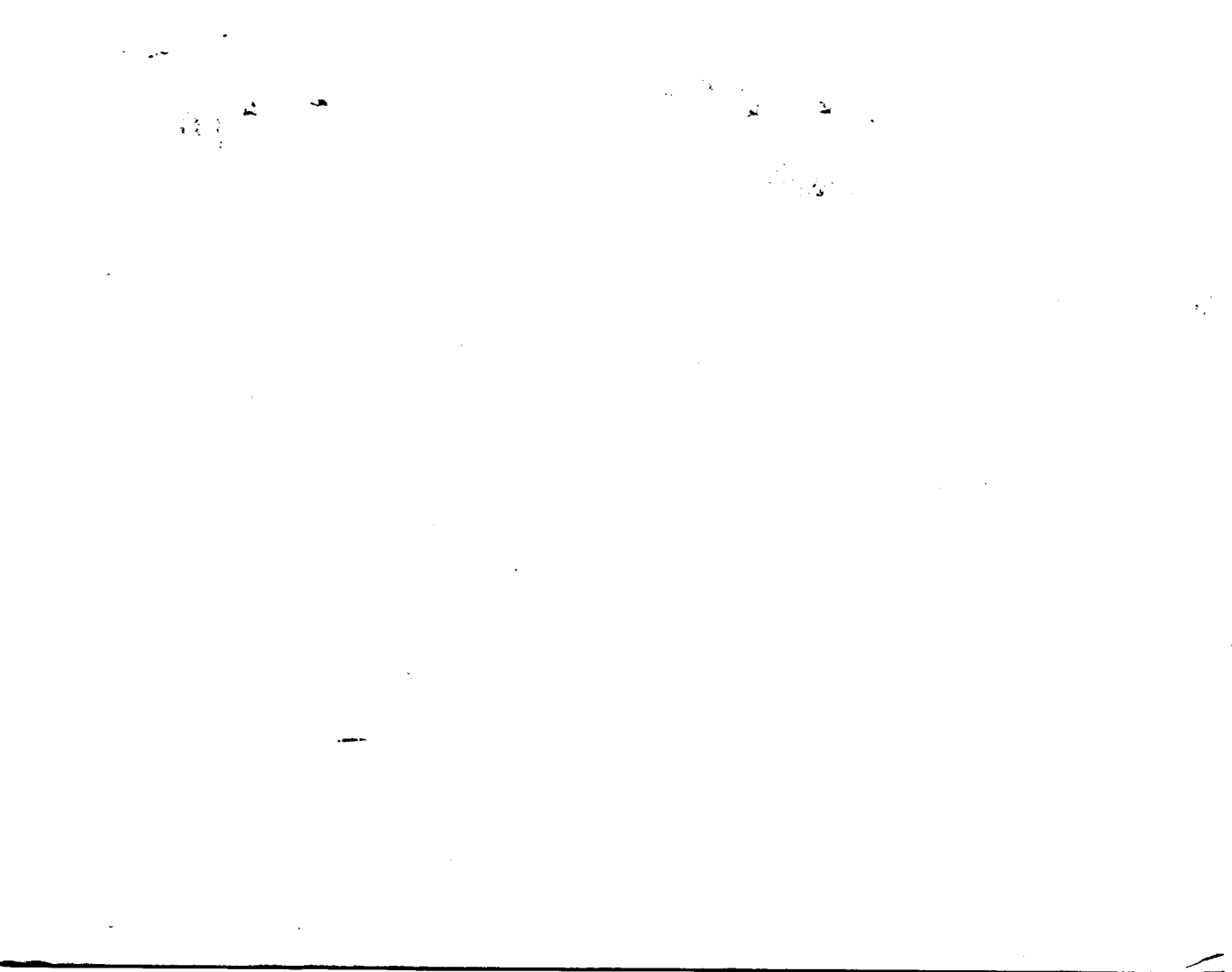
I hereby certify that I attended the birth of this child, who was Stillborn at 2:30 a.m.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Paul W. Johnson  
(Physician or midwife)

Give names added from a supplemental report.

Address Leviaton, Idaho  
Filed 9/8/1922 F.T. Harris, M.D.  
Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

Johnson  
State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **39416**  
Registered No. **148**

1. PLACE OF DEATH **RECEIVED**  
County of **my place** Registration District No. **96**  
City of **Leoviston** Registration District No. **1009** (St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Stillborn C. Atkinson**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**  
(Write the word.)

6. DATE OF BIRTH **Aug 17** 19**22**  
(Month) (Day) (Year)

7. AGE **still born** IF LESS than 1 day  
Yrs. Mos. ds. how many **0** hrs.  
or **0** min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

~~Clinton Walker~~  
~~Frank M. Walker~~

## 9. BIRTHPLACE

(State or Country)

**Idaho**

## 10. NAME OF FATHER

**F. W. Atkinson**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Mont.**

## 12. MAIDEN NAME OF MOTHER

**Kathleen Walker**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Mont.**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**Nathaniel Walker**

(Address)

**Clarksonton wash**

## 15.

Filed

**9/8/ 19 22**

**F. T. Harris, M.D.**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Aug** 19**22**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 17 19 22** to **Aug 17 19 22**

that I last saw h. alive on 19. and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as **mother still born. was bunted by cow which was probable cause of intrauterine death**  
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

**Paul W. Johnson M.D.**

**8/17 19 22** (Address) **Leoviston Ida**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **Born on St. Joe, Hoek; Leoviston** yrs. mos. days. State **Ida** yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence **Clarksonton wash.**

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Leoviston Idaho** **8/17 19 22**

## 20. UNDERTAKER

## ADDRESS

**Vassallo Indico** **Leoviston Ida**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

243-226-039-49  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Poway  
City of POWAY  
No. 25  
Hospital 2072  
Registration District No. 2072  
Primary Registration District No. 2072  
File No. 105194  
Registered No. 443  
FULL NAME OF CHILD Not named  
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>No</u> (To be answered only in event of plural births)	and {	Number in order of birth <u>10</u>	Legitimate? <u>yes</u>	Date of birth <u>Sept 26</u> 1922 (Month) (Day) (Year)
----------------------------	---	-------	------------------------------------	------------------------	---

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 9

FULL NAME <u>Jacob C. Kulin</u>	FATHER	FULL MAIDEN NAME <u>Christine Kurty</u>	MOTHER
RESIDENCE <u>American Falls</u>		RESIDENCE <u>American Falls</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Russia</u>		BIRTHPLACE <u>Russia</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

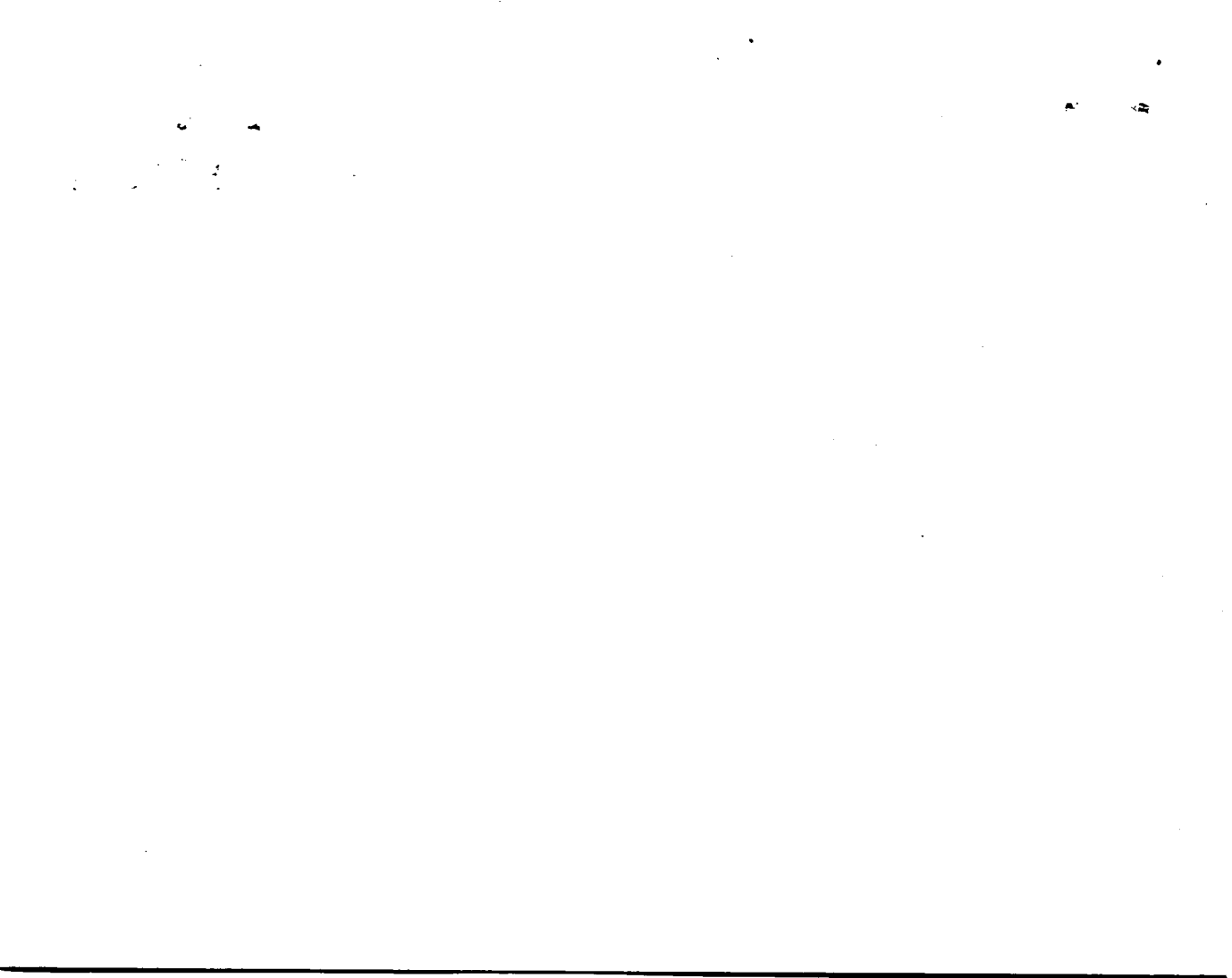
I hereby certify that I attended the birth of this child, who was stillborn at 11 a. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) V. J. Logan  
Physician  
(Physician or midwife)

Give names added from a supplemental report.  
....., 19.....  
Registrar.

Address American Falls  
Filed 10-8 1922 Richard K. Noth  
Registrar.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

39431

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Power  
City of American FallsRegistration District No. 25Primary Registration District No. 2172No. 1  
STATISTICSFile No. 1Registered No. 166

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Still born

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

white

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

9 26 1922  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Jacob C. Kulm

## 11. BIRTHPLACE OF FATHER

(State or Country)

Russia

## 12. MAIDEN NAME OF MOTHER

Christine Kutz

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed 9-26- 1922R. F. Noth  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

9 26 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Dead when arrived

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) U. S. Logan M. D.10/5 1922 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

19

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

255-216-042-393  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Latah **RECEIVED**  
City of Buhl **SEP - 9 1922** **CERTIFICATE OF BIRTH**  
No. \_\_\_\_\_ St. Registration District No. 09 File No. 105167  
Hospital \_\_\_\_\_ Primary Registration District No. 2087 Registered No. \_\_\_\_\_  
FULL NAME OF CHILD \_\_\_\_\_  
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>8-16-1922</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth... 1 Number of child of this mother now living, including present birth... 0

FATHER		MOTHER	
FULL NAME <u>Gordon Vinton Bennett</u>	FULL MAIDEN NAME <u>Nazel Anna Lilly</u>		
RESIDENCE <u>Buhl</u>	RESIDENCE <u>Buhl</u>		
COLOR <u>Wh</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>Wh</u> AGE AT LAST BIRTHDAY <u>28</u> (Years)		
BIRTHPLACE <u>Mass.</u>	BIRTHPLACE <u>Calo.</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 5 a. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

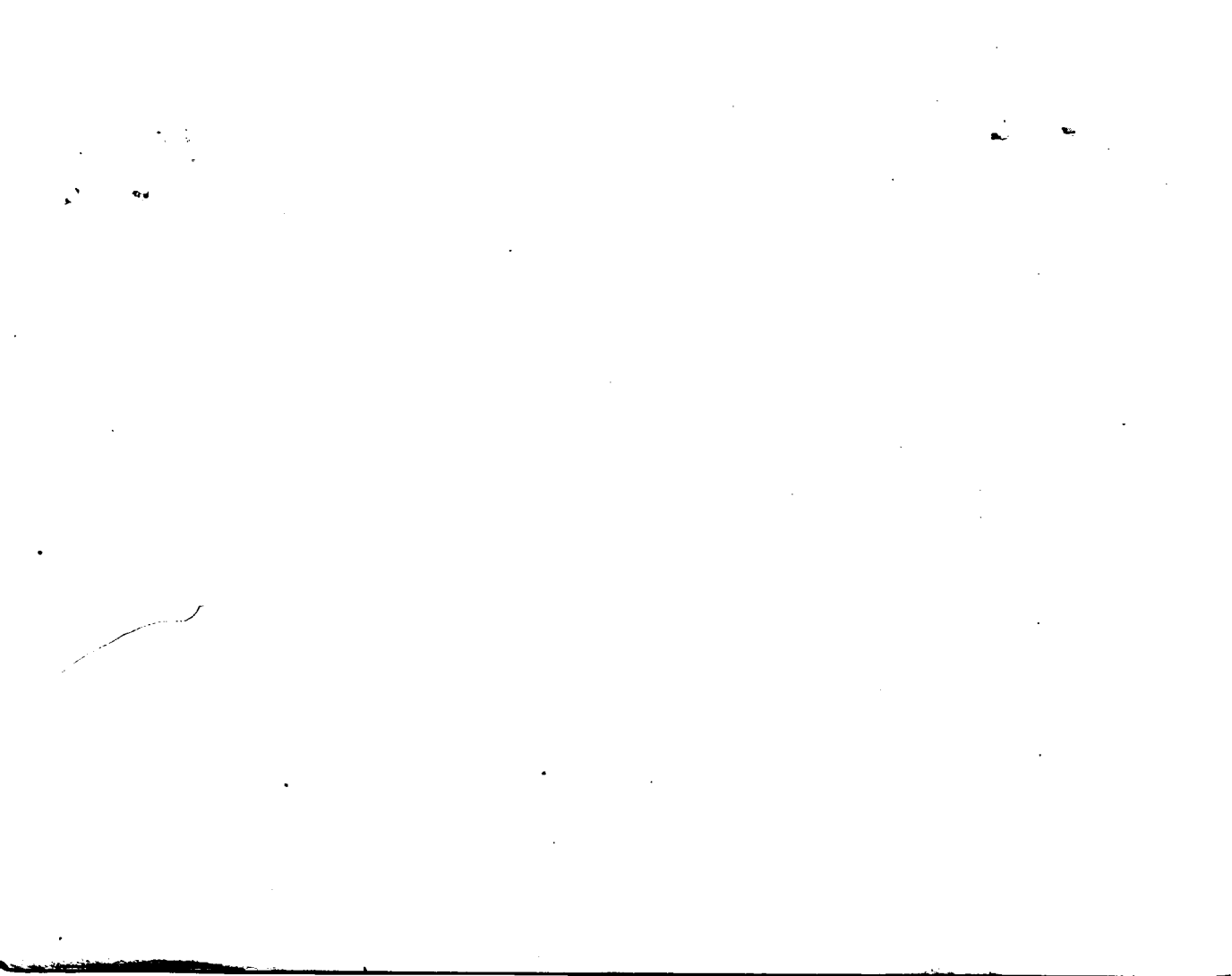
(Signature) Geo. J. Murphy  
(Physician or midwife)

Give names added from a supplemental report.

\_\_\_\_\_, 19\_\_\_\_

Registrar.

Address Buhl  
Filed AUG 31 1922 J. H. Murphy  
Registrar.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **39735**

## 1. PLACE OF DEATH

County of *Lewin*City of *Buhl*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Baley Bennett*

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Female*

## 4. COLOR OR RACE

*white*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

*8-16-1922*  
(Month) (Day) (Year)

## 7. AGE

*✓*  
Yrs. Mos. ds.

IF LESS than 1 day  
how many *✓* hrs.  
or *✓* min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work *✓*(b) General nature of industry, business or establishment in which employed (or employer) *✓*

## 9. BIRTHPLACE

(State or Country)

*Buhl, Ida.*

## 10. NAME OF FATHER

*Gordon P. Bennett*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Mass.*

## 12. MAIDEN NAME OF MOTHER

*Hazel Anna Lee*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Colo.*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Gordon P. Bennett*

(Address)

*Buhl, Ida.*

## 15.

Filed *8-16-1922*

*J. H. Winters*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*8-16-1922*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *8-16-1922* to *8-16-1922*

that I last saw him *✓* alive on *✓* *1922*

and that death occurred on the date stated above, at *✓* M.

The CAUSE OF DEATH\* was as follows:

*Heart failure*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*Geo. Jennings* M. D.

*8-16-1922* (Address) *Buhl, Ida.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Buhl* *8/16-1922*

## 20. UNDERTAKER

ADDRESS

*J. H. Winters* *Buhl, Ida.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

296-221-042-469  
PLACE OF BIRTH

County of Twin Falls

City of Buhl

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

RECEIVED DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
SEP 9 1922  
BUREAU OF VITAL  
STATISTICS

Registration District No. \_\_\_\_\_

Primary Registration District No. 2087

File No. 105173

Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>Girl</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>8</u> <u>21</u> <u>1922</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bactericidal solution was used in eyes? Argyrol 20.20

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 4

FULL NAME FATHER  
O. S. Brooks

RESIDENCE Buhl

COLOR white AGE AT LAST BIRTHDAY 30  
(Years)

BIRTHPLACE Ark.

OCCUPATION Farmer

FULL MAIDEN NAME MOTHER  
Eunice Dorman

RESIDENCE Buhl

COLOR white AGE AT LAST BIRTHDAY 30  
(Years)

BIRTHPLACE Ark.

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn 1300 M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) A. S. McCusky

(Physician or midwife)

Give names added from a supplemental report.

Address Buhl

Filed AUG 31 1922

Registrar.

Registrar.

NY 1001

5

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH

County of *Iron Hills*  
City of *Buhl*  
If death occurs away from usual residence, give facts called for under special information.

RECEIVED

CERTIFICATE OF DEATH  
Registration District No. *39*  
Registration District No. *2087*  
BUREAU OF VITAL STATISTICS

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *39439*  
Registered No. ....  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Female*

4. COLOR OR RACE

*white*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

*Aug. 21 1922*  
(Month) (Day) (Year)

7. AGE

*still born*  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Buhl Idv*

10. NAME OF FATHER

*O. G. Brooks*

11. BIRTHPLACE OF FATHER

(State or Country)

*Arkansas*

12. MAIDEN NAME OF MOTHER

*Emmie Lorman*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Arkansas*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*O. G. Brooks*

(Address)

*Buhl Idv*

15.

Filed *8-22-22* 1922.

*J. T. Murphy*  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Sept 1 1922*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191.

that I last saw *h* alive on 191.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Still born, Had been dead some days & cause not known*  
(Duration) Yrs. Mos. ds.

Contributory (Secondary)

(Duration)

(Signed)

*8/22/1922* (Address) *Buhl Idv*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted  
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

*Buhl Cemetery*

DATE OF BURIAL

*8-22-22* 1922.

20. UNDERTAKER

*None*

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



666 -206. 842496

Form V. S. No. 11-C-35m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of Terrell

RECEIVED

OCT 2 1922

CERTIFICATE OF BIRTH

City of Terrell

BUREAU OF VITAL

Registration District No. 37File No. 105180No. R. R. St.Primary Registration District No. 2085

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Vivian Irene Woods

Sex of Child

FemaleTwin  
Triplet  
or other? —and { Number  
in order  
of birth —

Legitimate?

yes

Date of Birth

8-61922

(Month) (Day) (Year)

FULL NAME

FATHER

Frank Woods

RESIDENCE

Terrell

COLOR

whiteAGE AT LAST  
BIRTHDAY33  
(Years)

BIRTHPLACE

Nebraska

OCCUPATION

FamerFULL  
MAIDEN  
NAME

MOTHER

Glara Frost

RESIDENCE

Terrell

COLOR

whiteAGE AT LAST  
BIRTHDAY25  
(Years)

BIRTHPLACE

Alabama

OCCUPATION

HousewifeNumber of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Born Dead, at 7 a M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

H. N. LuteTerrell Idg  
(Physician or midwife)

Given names added from a supplemental report.

19.

Address \_\_\_\_\_

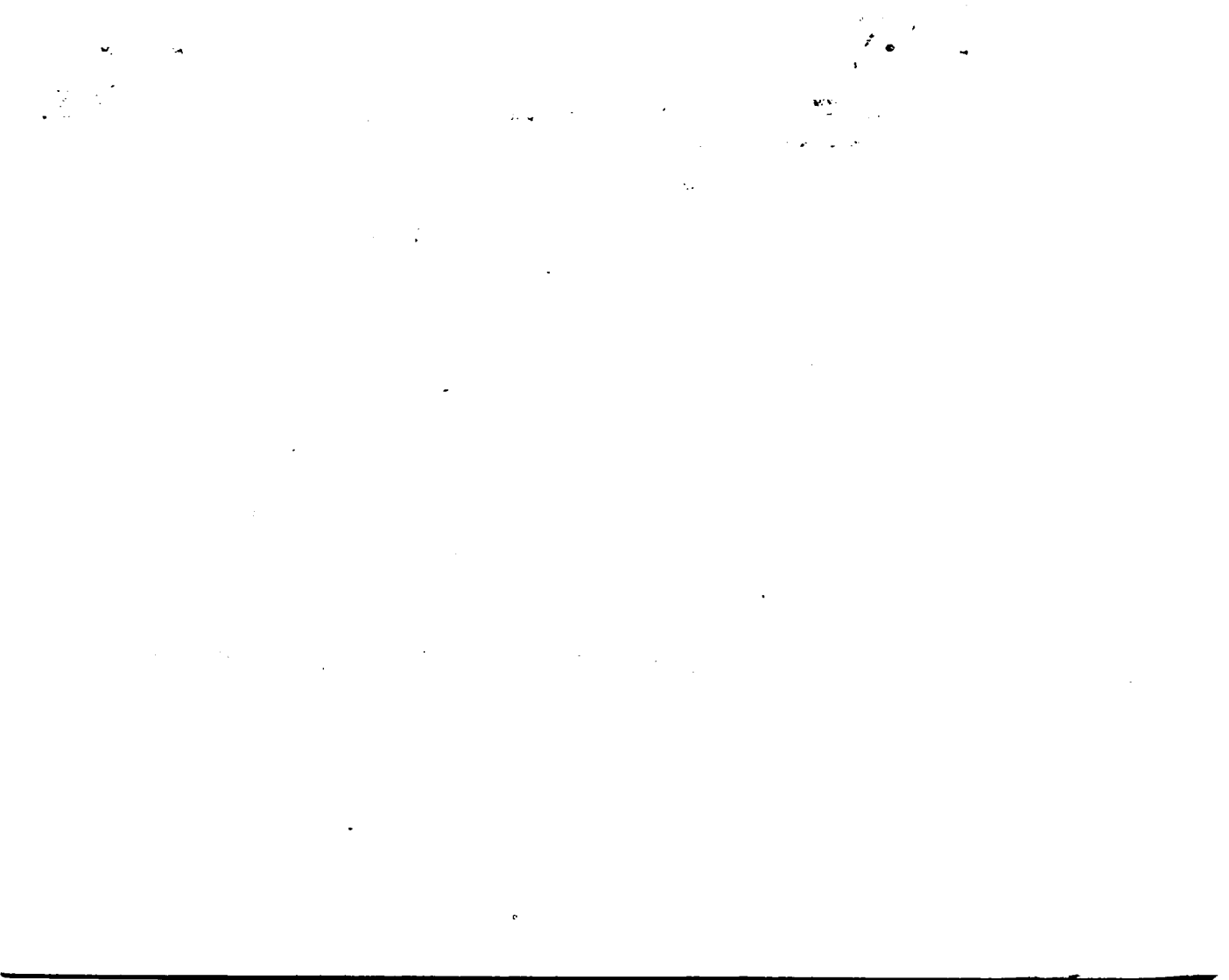
Filed Oct. 1 1922

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate. In plain print, so that it may be properly classified. EXACTLY, WITH UNFADING INK.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. ~~DECEASED~~ DEATH

County of Twin Falls Registration District No. 37  
City of Almo Primary Registration District No. 2185  
St. Idaho

File No. 39130  
Registered No. 1510

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion Woods

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Aug 6 1922  
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank Woods

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Clarice Frank

13. BIRTHPLACE OF MOTHER

(State or Country)

Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G Frank Woods

(Address)

Twin Falls Ida

Filed Aug 9 1922

John F. Coyle  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 6 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8/6 1922 to 8/6 1922  
that I last saw him at on 8/6 1922  
and that death occurred on the date stated above, at 30 PM.  
The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) Yrs. mos. 45 days

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Wm Rute M. D.  
8/6 1922 (Address) Twin Falls Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

8-7-1922

20. UNDERTAKER

J E Rute

ADDRESS

Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

345-125-092-145  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Lion Falls DOB 1922  
City of Lion Falls Id. BUREAU OF VITAL STATISTICS  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 37 File No. \_\_\_\_\_  
Hospital County Primary Registration District No. 1085 Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twins or other? <u>and</u> { } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>9 25 1922</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>Walph Cunningham</u>	FULL MAIDEN NAME	<u>Essie Adekin</u>
RESIDENCE	<u>Contact Nev.</u>	RESIDENCE	<u>Contact Nev.</u>
COLOR	<u>W</u>	COLOR	<u>W</u>
AGE AT LAST BIRTHDAY	<u>24</u> (Years)	AGE AT LAST BIRTHDAY	<u>23</u> (Years)
BIRTHPLACE	<u>Creston Iowa</u>	BIRTHPLACE	<u>Bernal Utah</u>
OCCUPATION	<u>farmer</u>	OCCUPATION	<u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at \_\_\_\_\_  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. W. Wilson

Physician  
(Physician or midwife)

Give names added from a supplemental report.

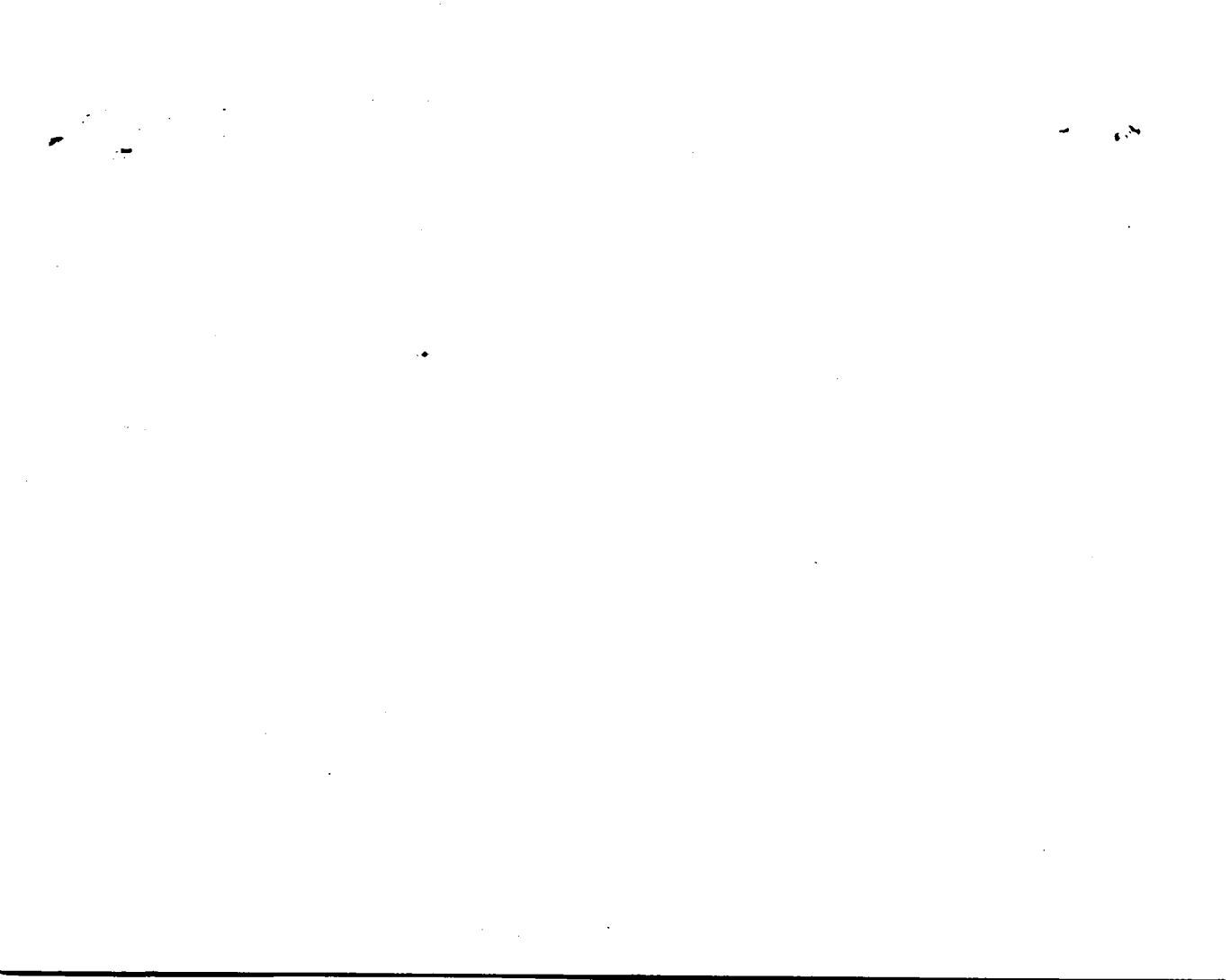
\_\_\_\_\_, 19\_\_\_\_

Registrar.

Address \_\_\_\_\_

Filed Oct. 1-22

John T. Coughlin  
Registrar.



WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

NOV 18 1922

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

40193

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU

ST.

Infant Cunningham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov. 1 - 1922

John J. Coughlin  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Signed)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



491-212-001-273

## PLACE OF BIRTH

County of AdaCity of BonaiNo. St. Stephens

Hospital

Full Name of Child None

RECEIVED

OCT 2 1922

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11—25m-6-15-18

## CERTIFICATE OF BIRTH

Registration District No. 2File No. 105251Primary Registration District No. 1004Registered No. 377

SEX OF CHILD <u>F.</u>	Twin Triplet or other? <u>N</u>	{ and } Number in order of birth <u>6</u>	Legiti- mate? <u>Yes</u>	DATE OF BIRTH <u>9-12-22</u> (Month) (Day) (Year)
FULL NAME <u>John Drake</u>		FATHER		
RESIDENCE <u>Bonai</u>		MOTHER <u>Rose Bateman</u>		
RESIDENCE <u>Bonai</u>		RESIDENCE <u>Bonai</u>		
COLOR <u>Wh.</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)	COLOR <u>Wh.</u>		
BIRTHPLACE <u>Missouri</u>		AGE AT LAST BIRTHDAY <u>31</u> (Years)		
OCCUPATION <u>Rancher</u>		BIRTHPLACE <u>Wyoming</u>		
OCCUPATION <u>Rancher</u>		OCCUPATION <u>Farmer</u>		

Number of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 10 P.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) S. J. Sweeney

(Physician or midwife)

Given names added from a supplemental report

Address P. R. ParkFiled Sept 18 1922

Registrar

Registrar

Signature will have date not later than 1st of January 1918. If signature is not given, the name of the child will be given in the case of a child.

PLACE OF BIRTH

City of *San Francisco*

No. *12*

Full Name of Child *William*

Residence *San Francisco*

Color *White*

Birthplace *San Francisco*

Occupation *Teacher*

Age at last birthday *10*

Residence *San Francisco*

Color *White*

Birthplace *San Francisco*

Occupation *Teacher*

Age at last birthday *10*

Residence *San Francisco*

Color *White*

Birthplace *San Francisco*

Occupation *Teacher*

Age at last birthday *10*

Residence *San Francisco*

Color *White*

Birthplace *San Francisco*

CERTIFICATE OF BIRTH  
BUREAU OF VITAL STATISTICS  
STATE OF CALIFORNIA

Registered *Yes*

Primary Registrar of District No. *1000*

Full Name of Child *William*

Residence *San Francisco*

Color *White*

Birthplace *San Francisco*

Occupation *Teacher*

Age at last birthday *10*

Residence *San Francisco*

Color *White*

Birthplace *San Francisco*

Occupation *Teacher*

Age at last birthday *10*

Residence *San Francisco*

Color *White*

Birthplace *San Francisco*

Occupation *Teacher*

Age at last birthday *10*

Residence *San Francisco*

Color *White*

Birthplace *San Francisco*

Occupation *Teacher*

CERTIFICATE OF BIRTH

Number of children of this mother now living *10*

Number of children of this mother now living *10*

Number of children of this mother now living *10*

Number of children of this mother now living *10*

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Number of children of this mother now living *10*

Number of children of this mother now living *10*

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Ada Registration District No. 2  
 City of Boise Primary Registration District No. 1004  
 (No. 410 St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Drake

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 39182

Registered No. 218

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED

Female White Single

## 6. DATE OF BIRTH

Sept. 12 1922  
 (Month) (Day) (Year)

## 7. AGE

Still Born  
 Yrs. Mos. ds. IF LESS than 1 day  
 how many hrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed 9-14 1922

R. L. Pratt  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sept. 12 1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-12 1922 to 9-12 1922

that I last saw him alive on 9-12 1922  
 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH\* was as follows:

Still born.  
Premature.

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

9/13/22 (Signed) Inspector M. D.

(Address) Boise

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery Co. Rd. 9/14/22

## 20. UNDERTAKER

Schneiter & Hidenbach Boise

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name or origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

City of Eagle **Bureau of Vital Statistics** 9 + 10 File No. S 34  
 No. \_\_\_\_\_ St. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. 34  
 Hospital \_\_\_\_\_  
 FULL NAME OF CHILD Floyd Wood 105280

Sex of Child <u>Male</u>	Twin, Triplet or other? <u>-</u>	and { Number in order of birth <u>-</u>	Legiti- mate? <u>Yes</u>	Date of Birth <u>Sept-12</u> 19 <u>22</u> (Month) (Day) (Year)
FULL NAME FATHER <u>David Wood</u>			FULL MAIDEN NAME MOTHER <u>Mary Ellen Campbell</u>	
RESIDENCE <u>Eagle</u>			RESIDENCE <u>Eagle</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>45</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>33</u> (Years)		
BIRTHPLACE <u>Arkansas</u>			BIRTHPLACE <u>Arkansas</u>	
OCCUPATION <u>Merchant</u>			OCCUPATION <u>House wife</u>	

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 5

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\***

I hereby certify that I attended the birth of this child, who was stillborn at 9 P.M.  
 on the date above stated. (Born alive or stillborn)

{ \*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Signature) Wm. H. Hall  
 \_\_\_\_\_  
 (Physician or midwife)

Given names added from a supplemental report. \_\_\_\_\_ 19\_\_\_\_  
 Address Eagle  
 File Sept. 13 19\_\_\_\_ Registrar Eagle Idaho



## CERTIFICATE OF DEATH

39196 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 9+10  
County of Blaine Primary Registration District No. 22  
City of Eagle (No. 22 St.) Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Floyd wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.

Male white Single  
(Write the word.)

6. DATE OF BIRTH.

Sept 12 1922  
(Month) (Day) (Year)

7. AGE

Steel burner

IF LESS than 1 day  
how many hrs. or  
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Eagle Idaho

10. NAME OF FATHER

David wood

11. BIRTHPLACE OF FATHER

(State or Country) Arkansas

12. MAIDEN NAME OF MOTHER

Mary Ellen Campbell

13. BIRTHPLACE OF MOTHER

(State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) +

(Address) W. J. Woods Eagle Idaho

15.

Filed

Sept 13 1912

22

Green

Local Registrar

16. DATE OF DEATH

Sept 12 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 12 1922 to Sept 12 1922

that I last saw him alive on Sept 12 1922

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Dead in utero  
at about 6 months  
gestation  
(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

Not Known

(Duration) — yrs. — mos. — ds.

(Signed) Wm. H. Hall M. D.

19 (Address) Eagle

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? +

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Paul Cemetery

Sept 13 1912

20. UNDERTAKER

ADDRESS

Wm. H. Hall

Boon

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

118 22001-381  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
RECEIVED  
NOV 8 1922  
CERTIFICATE OF BIRTH

S

County of Ada  
City of Bosse  
No. 1107 St. Gene Registration District No. 20 File No. 105329  
Hospital \_\_\_\_\_ Primary Registration District No. 1004 Registered No. 447

FULL NAME OF CHILD Jayo  
(Certificate of no value without full name of child.)

Sex of Child <u>Fe</u>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>10/21</u> (Month) (Day) (Year) <u>1922</u>
------------------------	---	---------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth. 3 Number of child of this mother now living, including present birth. 2

FATHER		MOTHER	
FULL NAME <u>John Jayo</u>	FULL MAIDEN NAME <u>Isabel Chopitea</u>		
RESIDENCE <u>RFD # 4</u>	RESIDENCE <u>RFD # 4</u>		
COLOR <u>Bl.</u> AGE AT LAST BIRTHDAY <u>42</u> (Years)	COLOR <u>Bl.</u> AGE AT LAST BIRTHDAY <u>31</u> (Years)		
BIRTHPLACE <u>Spain</u>	BIRTHPLACE <u>Spain</u>		
OCCUPATION <u>Rancher</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Fred J. Litchner  
Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address Oakland Blvd. Boise

Filed Oct 23 1922 R. H. Paul

Registrar.

Registrar.

SEVERAL REASONS  
FOR EACH CHILD

DEPARTMENT

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City .....  
                  { Street .....  
                  { County .....

File Number ..... **105329** .....

Registration Dist. No. ....

Sex of Child..... **Female** .....

Date of Birth ..... **192** .....

Father .....  
                  Full Name

Mother .....  
                  Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

.....  
Child's Name in Full

.....  
Signature of Father or Mother

Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

----- IT SHOWS AT LATER PERIODS OF LIFE: -----

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

## PLACE OF DEATH

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. **39491**Registered No. **254**County of **Ada**  
City of **Boise**Registration District No. **2**  
Primary Registration District No. **1004**  
(No. **1107 Grove** St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Infant Jago**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
(Write the word.)

## 6. DATE OF BIRTH

**Oct 21 1922**  
(Month) (Day) (Year)

## 7. AGE

**Stillborn**  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) **Boise**

## 10. NAME OF FATHER

**John Jago**

## 11. BIRTHPLACE OF FATHER

(State or Country) **Spain**

## 12. MAIDEN NAME OF MOTHER

**Isabella Chopita**

## 13. BIRTHPLACE OF MOTHER

(State or Country) **Spain**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) **P. Jago** **Boise**

## 15.

Filed **10-23** 19**22****R. H. Pratt**  
Local Registrar

## 16. DATE OF DEATH

**10 21 1922**  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **10/21** 19**22** to **10/21** 19**22**that I last saw him alive on **10/21** 19**22**and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH\* was as follows:

**Stillborn**  
**Cord Prolapse of Umbilicus**  
(Duration) Yrs. mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Thos A. Putnam** M. D.**1722 19 22** (Address) **Boise**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**St. Johns Cemetery** **10/22 1922**

## 20. UNDERTAKER

## ADDRESS

**Shurtz Widenfaden** **Boise**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

577120-001-873  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Ada

NOV 3 1922

CERTIFICATE OF BIRTH 105331

City of BoniNo. 1600 St.Registration District No. 2

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 1004Registered No. 449

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>m</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 20</u> 192 <u>2</u> (Month) (Day) (Year)
-----------------------	---	-------	--------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3FULL NAME FATHER John EggerRESIDENCE BoniCOLOR W.AGE AT LAST  
BIRTHDAY 25  
(Years)BIRTHPLACE OhioOCCUPATION laborer.FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE BoniCOLOR W.AGE AT LAST  
BIRTHDAY 32  
(Years)BIRTHPLACE N.Y.OCCUPATION housewife

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated. (Residence or stillborn)\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.(Signature) John Egger m.d.

(Physician or midwife)

Give names added from a supplemental report.

\_\_\_\_\_, 192\_\_\_\_

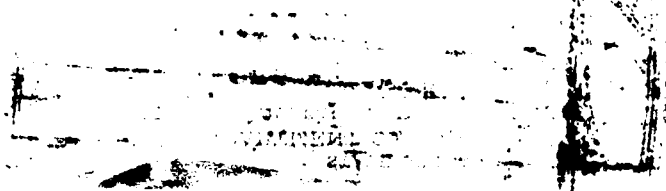
Address \_\_\_\_\_

Filed Oct 31 1922

Registrar.

Registrar.

Hold for data





MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **39175**  
Registered No. **226**  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Boise**  
County of **Ada**  
City of **Boise**  
Registration District No. **1004**  
Primary Registration District No. **Michigan**  
St. **Idaho**

RECEIVED  
OCT 2 1922  
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Infant Egger**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
(Write the word.)

6. DATE OF BIRTH **Sept 20 1922**  
(Month) (Day) (Year)

7. AGE **Stillborn**  
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **none**  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Boise Idaho**  
(State or Country)

10. NAME OF FATHER **John Egger**

11. BIRTHPLACE OF FATHER **Ohio**  
(State or Country)

12. MAIDEN NAME OF MOTHER **Clara Hatch**

13. BIRTHPLACE OF MOTHER **New York**  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **Wm Mc Bratney**  
(Address) **Boise Idaho**

15. Filed **9-20 1922** **R. H. Pratt**  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 20 1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **19** to **19**  
that I last saw h..... alive on **19**  
and that death occurred on the date stated above, at **5** M.  
The CAUSE OF DEATH\* was as follows:  
**Still born**

(Duration) Yrs. mos. ds.  
Contributory (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) **H. W. Bratney** M. D.  
**Sept 20 1922** (Address) **517 Empire B**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death yrs. mos. days. In the State yrs. mos. days.  
Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Ada Co. Cemetery** DATE OF BURIAL **9-20 1922**  
20. UNDERTAKER **Wm Mc Bratney** ADDRESS **Boise Idaho**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

93-106-003-462  
PLACE OF BIRTHSTATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bannock 00121 1922  
 City of Pocatello 00121 1922  
 No. 28 St. Registration District No. 28 File No. 8  
 Hospital Pocatello General Primary Registration District No. 2161 Registered No. 4578  
 FULL NAME OF CHILD Harold Williams (Still born)  
 (Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Sept 16</u> 192 <u>2</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? NoNumber of child of this mother, including present birth... 9 Number of child of this mother now living, including present birth... 7

FATHER  
 FULL NAME Frank Williams  
 RESIDENCE Pocatello  
 COLOR white AGE AT LAST BIRTHDAY 42 (Years)  
 BIRTHPLACE Idaho  
 OCCUPATION laborer

MOTHER  
 FULL MAIDEN NAME Mary Moser  
 RESIDENCE Pocatello  
 COLOR white AGE AT LAST BIRTHDAY 38 (Years)  
 BIRTHPLACE Switzerland  
 OCCUPATION housewife

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 2:40 P. M.  
 on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Carl W. Clark M.D.  
 Physician  
 (Physician or midwife)

Give names added from a supplemental report.

Address

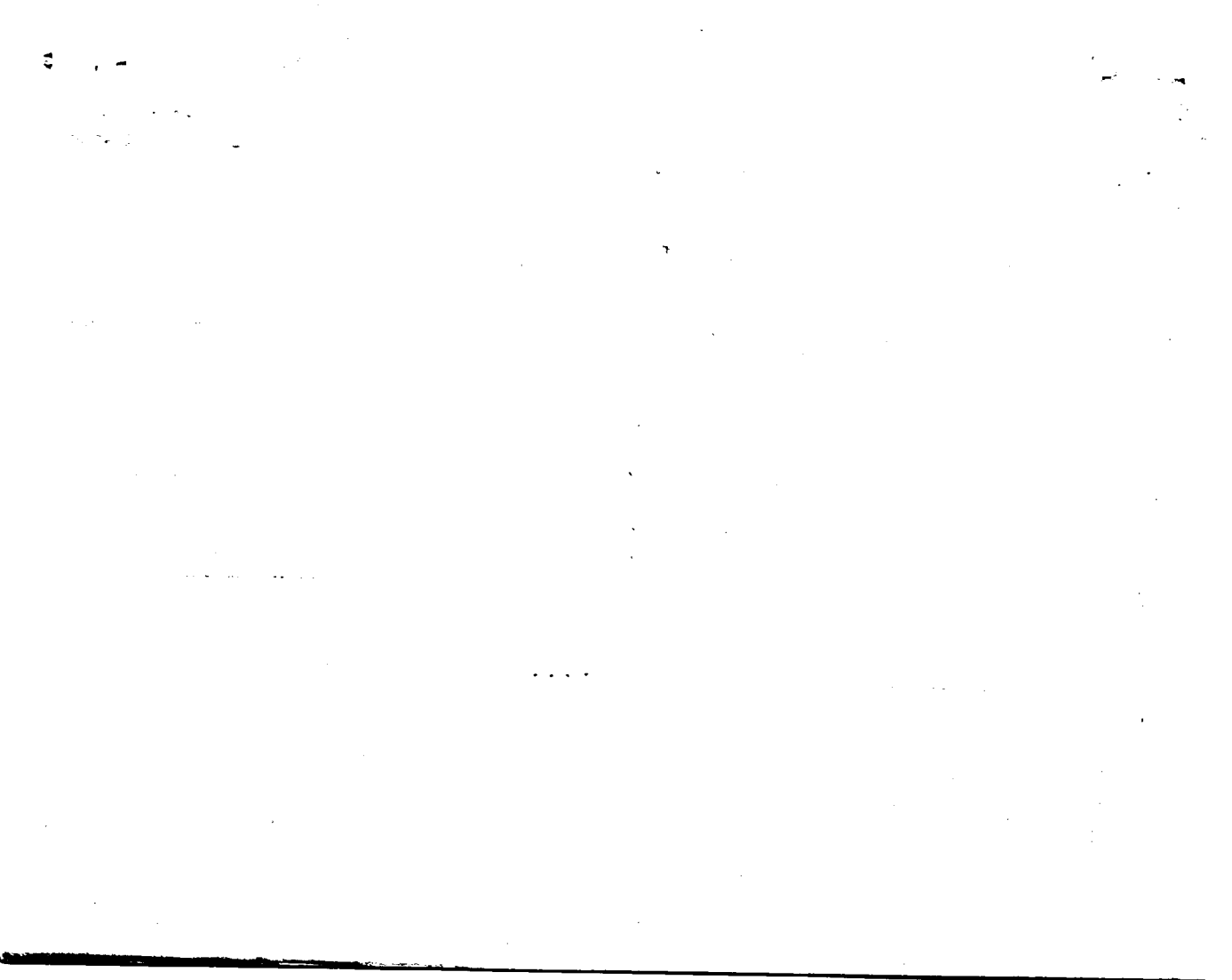
Pocatello

Filed

9/1 1922

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

39506

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH Bannock District No. 28  
County of Bannock Registration District No. 2161  
City of Pocatello (No. Pocatello Gen Has St.)

File No. 53  
Registered No. 3909

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Williams

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single (Write the word.)  
6. DATE OF BIRTH Sept 6 1922  
(Month) (Day) (Year)  
7. AGE Still Born IF LESS than 1 day how many..... hrs. or..... min.?  
8. OCCUPATION (a) Trade, profession or particular kind of work none  
(b) General nature of industry, business or establishment in which employed (or employer)  
9. BIRTHPLACE Pocatello, Id  
(State or Country)  
10. NAME OF FATHER Frank Williams  
11. BIRTHPLACE OF FATHER Idaho  
(State or Country)  
12. MAIDEN NAME OF MOTHER Mary Moser  
13. BIRTHPLACE OF MOTHER Switzerland  
(State or Country)  
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Frank Williams  
(Address) 915 So. Harrison  
15. Sept 6 1922  
Filed (Month) (Day) (Year) Phasing  
Local Registrar

16. DATE OF DEATH Sept 6 1922  
(Month) (Day) (Year)  
17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1922, to Sept 6 1922  
that I last saw him alive on Sept 6 1922  
and that death occurred on the date stated above, at 2:40 M.  
The CAUSE OF DEATH\* was as follows:  
Stillborn.

(Duration) Yrs. mos. ds.  
Contributory (Secondary) Premature  
(Duration) yrs. mos. ds.  
(Signed) Carl W. Clapp M. D.  
Sept 19 22 (Address) Pocatello, Id

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days  
Where was disease contracted if not at place of death?  
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mt View Cem. DATE OF BURIAL Sept 7 1922  
20. UNDERTAKER H. L. Mc Han ADDRESS Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

863-202-000  
PLACE OF BIRTH-73

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

105521

S

County of Bömer  
City of Priest River

No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 85 File No. 3

Hospital \_\_\_\_\_ Primary Registration District No. 2185 Registered No. 214

FULL NAME OF CHILD Helen Hollingsworth  
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>Yes</u>	Date of birth <u>Oct. 2</u> 192 <u>2</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME <u>Cyrus Harrison Hollingsworth</u>	FULL MAIDEN NAME <u>Lillian Pickett</u>	FULL NAME <u>Lillian Pickett</u>	FULL MAIDEN NAME <u>Lillian Pickett</u>
RESIDENCE <u>Priest River</u>	RESIDENCE <u>Priest River</u>	RESIDENCE <u>Priest River</u>	RESIDENCE <u>Priest River</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>18</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>21</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>21</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Mo.</u>	BIRTHPLACE <u>Nebraska</u>	BIRTHPLACE <u>Nebraska</u>	BIRTHPLACE <u>Nebraska</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 10:15 a. M. on the date above stated.  
(Born live or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) A. D. Schlottbauer M.D.  
Physician  
(Physician or midwife)

Address Priest River Idaho

Filed Nov 1 1922 C. H. G. H. Registrar.

Registrar.

UNITED STATES DEPARTMENT OF JUSTICE  
BUREAU OF PRISON  
CRIMINAL DIVISION

City of \_\_\_\_\_ No. \_\_\_\_\_  
 Registered in \_\_\_\_\_  
 Prisoner's Classification Number \_\_\_\_\_  
 Name of Prisoner \_\_\_\_\_  
 (Classification of Prisoner) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Height \_\_\_\_\_  
 Weight \_\_\_\_\_  
 Eyes \_\_\_\_\_  
 Hair \_\_\_\_\_  
 Skin \_\_\_\_\_  
 Markings \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Education \_\_\_\_\_  
 Religion \_\_\_\_\_  
 Marital Status \_\_\_\_\_  
 Place of Birth \_\_\_\_\_  
 Date of Entry \_\_\_\_\_  
 Reason for Entry \_\_\_\_\_  
 Sentence \_\_\_\_\_  
 Parole Date \_\_\_\_\_  
 Parole Conditions \_\_\_\_\_

Color \_\_\_\_\_  
 Height \_\_\_\_\_  
 Weight \_\_\_\_\_  
 Eyes \_\_\_\_\_  
 Hair \_\_\_\_\_  
 Skin \_\_\_\_\_  
 Markings \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Education \_\_\_\_\_  
 Religion \_\_\_\_\_  
 Marital Status \_\_\_\_\_  
 Place of Birth \_\_\_\_\_  
 Date of Entry \_\_\_\_\_  
 Reason for Entry \_\_\_\_\_  
 Sentence \_\_\_\_\_  
 Parole Date \_\_\_\_\_  
 Parole Conditions \_\_\_\_\_

THIS CARD IS TO BE FILLED OUT BY THE PRISONER AT THE TIME OF HIS ENTRY INTO THE PRISON. IT IS TO BE KEPT IN THE PRISON AND NOT TO BE TAKEN OUT. IT IS TO BE USED FOR THE PURPOSES OF THE PRISON AND NOT FOR ANY OTHER PURPOSE.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

39559

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Bonner Registration District No. 85  
City of Priest River Registration District No. 2145  
City of STANBILT (St.)File No. 2  
Registered No. 69 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Hollingsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

Oct. 2 1922  
(Month) (Day) (Year)

## 7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day  
how many 0 hrs.  
or 0 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)None

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Cyrus Harrison Hollingsworth

## 11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

## 12. MAIDEN NAME OF MOTHER

Lillian Pickett

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cyrus Harrison Hollingsworth  
(Address) Priest River

## 15.

Filed Nov 1 1922 C. H. Gentry  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Oct. 2 1922  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct. 2 1922, to Oct. 2 1922 that I last saw her alive on Oct 2 1922 and that death occurred on the date stated above, at 10:15 AM

The CAUSE OF DEATH\* was as follows:

Stillborn (7 months).  
(Placenta praevia.)(Duration) ✓ Yrs. ✓ mos. ✓ ds.Contributory  
(Secondary)Premature(Duration) ✓ yrs. ✓ mos. ✓ ds.(Signed) A. D. Schlottbauer M. D.10/2 1922 (Address) Priest River

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ✓ yrs. ✓ mos. ✓ days. In the State ✓ yrs. ✓ mos. ✓ days

Where was disease contracted if not at place of death?

Former or usual residence Priest River

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Priest River Oct. 2 1922

## 20. UNDERTAKER

## ADDRESS

Cyrus Hollingsworth Priest River

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 20 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK- THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

86K-109-012-386

PLACE OF BIRTH

County of Idaho

City of Moore

No. .... St.

Hospital .....

FULL NAME OF CHILD .....

RECEIVED  
OCT 21 1922  
BUREAU OF VITAL  
STATISTICS  
Registration District No. ....

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. B. No. 11-C-25m-0-07

S  
105526

File No. ....

Primary Registration District No. .... Registered No. ....

Sex of Child Male Twin Triplet or other? No and { Number in order of birth 1 Legitimate? Yes Date of Birth 9-9-22  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
Full Name Thomas Carlyle Young

RESIDENCE Moore, Idaho

COLOR White AGE AT LAST BIRTHDAY 39  
(Years)

BIRTHPLACE Mo

OCCUPATION Merchant

MOTHER  
Full Maiden Name Phoebe Lee Thomas

RESIDENCE Moore, Idaho

COLOR White AGE AT LAST BIRTHDAY 29  
(Years)

BIRTHPLACE Virginia

OCCUPATION House wife

Number of child of this mother, including present birth...1..... Number of children of this mother now living, including present birth...0.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born at 10:20 P.  
on the date above stated. (Born alive or Stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. L. ...  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Arco, Idaho

Filed 9/10-22 9-19-22  
Registrar

RECEIVED FOR THE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.



RECEIVED FOR THE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

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OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

463-123.01X-443

PLACE OF BIRTH

Form V. S. No. 11—25m-6-14-18

County of *Canyon*

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

City of *Roswell*

CERTIFICATE OF BIRTH

S

105531

No. \_\_\_\_\_

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Registered No. *65*

Full Name of Child *Stilleborn Molar*

SEX OF CHILD <i>Male</i>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legiti- mate? <i>Yes</i>	DATE OF BIRTH <i>Aug 23 1922</i> (Month) (Day) (Year)
FULL NAME <i>Clarence Molar</i>	FATHER		FULL MAIDEN NAME <i>Lothe Dutton</i>	MOTHER
RESIDENCE <i>Roswell Ida</i>			RESIDENCE <i>Roswell Ida</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>313</i> (Years)		COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>29</i> (Years)
BIRTHPLACE <i>Ore</i>			BIRTHPLACE <i>N.D.</i>	
OCCUPATION <i>Farmer</i>			OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth *3* Number of children of this mother now living, including present birth *3*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was *Stilleborn*, at *119* M on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *J. M. Mitchell*

(Physician or midwife)

Given names added from a supplemental report.

Address *Parma Ida*

Filed *8-28 1922* *Kulu Kaldor*

Registrar

Registrar

OFFICE OF THE  
ATTORNEY GENERAL



1241

1241

1241

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

766-230-DIK-655

PLACE OF BIRTH

ED

1922

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of CanyonCity of NampaNo. R# 3 St.VITAL CERTIFICATE OF BIRTH  
STATISTICSRegistration District No. 7File No. 105558

Hospital

Primary Registration District No. 2004 Registered No.

FULL NAME OF CHILD

Infant GoodmanSex of  
ChildFemaleTwin  
Triplet  
or other?✓

and

{

Number  
in order  
of birth✓{  
(To be answered only in event of plural births)Legiti  
mate?yesDate of  
Birth8/302219  
(Month) (Day) (Year)FULL  
NAMEFATHER  
Levis D. GoodmanFULL  
MAIDEN  
NAMEMOTHER  
Martha Oneal

RESIDENCE

R# 3 - Nampa

RESIDENCE

R# 3 Nampa

COLOR

WhiteAGE AT LAST  
BIRTHDAY43  
(Years)

COLOR

WhiteAGE AT LAST  
BIRTHDAY38  
(Years)

BIRTHPLACE

Missouri

BIRTHPLACE

Kansas

OCCUPATION

Farmer

OCCUPATION

HousewifeNumber of child of this mother, including present birth 8 Number of children of this mother now living, including present birth 7

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.Still born, at 1<sup>st</sup> A. M.  
(Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.(Signature) Leo W. Clutton M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address Nampa IdahoFiled Oct 10 1922 Pearle Dodds

Registrar

Registrar

Registration District No. \_\_\_\_\_

Primary Registration District No. 1000 Registered No.

UNITED STATES OF AMERICA

[illegible]

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

*[Handwritten signature]*

cc: [illegible]  
[illegible] (B)  
[illegible] (C)

cc: [illegible]  
[illegible] (B)  
[illegible] (C)

*[Handwritten signature]*

ARTS & CRAFTS

*[Handwritten signature]*

ARTS & CRAFTS

ОДНОУМЕРНОЕ ПОСРЕДСТВО ПЛАТЕЖА  
ИЛИ ПОСРЕДСТВО ПЛАТЕЖА С  
ОДНОУМЕРНЫМИ ЧЕКАМИ



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Canyon Registration District No. 2006  
City of Hamlet St.

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant GoodmanFile No. 39578  
Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE \_\_\_\_\_ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED \_\_\_\_\_

(Write the word.)

## 6. DATE OF BIRTH

8 30 1922  
(Month) (Day) (Year)

## 7. AGE

IF LESS THAN 1 day  
how many ✓ hrs.  
or ✓ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Lewis D. Goodman

## 11. BIRTHPLACE OF FATHER

(State or Country)

Mo

## 12. MAIDEN NAME OF MOTHER

Martha O'Neal

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Kans

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo W. Chittum

(Address)

Hamlet, Idaho

## 15.

Filed Oct 10 1922Pearle J. Lutz  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

8 30 1922  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 5:30 PM 8/29 1922 to 1:30 AM 9/30 1922  
that I last saw her alive on 8/29 1922  
and that death occurred on the date stated above, at \_\_\_\_\_ M.  
The CAUSE OF DEATH\* was as follows:Still born(Duration) ✓ Yrs. ✓ mos. ✓ ds.Contributory  
(Secondary)(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed)

Geo W. Chittum M. D.

(Address)

Hamlet, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ✓ yrs. ✓ mos. ✓ days. In the State ✓ yrs. ✓ mos. ✓ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Hamlet

## DATE OF BURIAL

8/30 1922

## 20. UNDERTAKER

✓

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

859-217-014-853  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

105595

S

CERTIFICATE OF BIRTH

County of Canyon  
City of Nampa  
No. Route # 3 Registration District No. 7 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2056 Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Not Named  
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Oct. 17th</u> 192 <u>2</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What bactericidal solution was used in eyes? Silver Nitrate 1 of 0 Sol.

Number of child of this mother, including present birth... 2 Number of child of this mother now living, including present birth... 1

FATHER  
FULL NAME Fred George Herget  
RESIDENCE Nampa, Idaho  
COLOR white AGE AT LAST BIRTHDAY 34 (Years)  
BIRTHPLACE Oregon  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Martha Helmer  
RESIDENCE Nampa, Idaho  
COLOR white AGE AT LAST BIRTHDAY 30 (Years)  
BIRTHPLACE Nebraska  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was born dead at 2:10 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Geo. R. Proctor  
Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address \_\_\_\_\_

Filed

Oct. 30 1922 Pearle D. Dodd  
Registrar.

Registrar.

102222

BUREAU OF VITAL STATISTICS  
DEPARTMENT OF HEALTH

## CERTIFICATE OF BIRTH

No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

## NAME OF CHILD

Full name of child at birth (last, first, middle)

Sex	Male	Female
Color	White	Black
Birthplace	State of New York	

Age at birth	1 year 10 months 10 days
Month of birth	October
Day of birth	10

Full name of child at birth	George Thomas
Residence	1111 1st Ave. N.Y.C.

Color	White
Birthplace	State of New York

Occupation	Student
------------	---------

Certificate of Attending Physician or Midwife	George Thomas
---	---------------

Signature of Registrar	George Thomas
------------------------	---------------

Signature of Registrar	George Thomas
------------------------	---------------

Signature of Registrar	George Thomas
------------------------	---------------

## 1. PLACE OF DEATH

County of Canyon  
City of HamperRegistration District No. 12Primary Registration District No. 2006

(No. \_\_\_\_\_ St.)

Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Horget

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Oct  
(Month)17  
(Day)1922  
(Year)

## 7. AGE

1 Yrs. 2 Mos. 2 ds.IF LESS than 1 day  
how many 1 hrs.  
or 1 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Fred George Horget

## 11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

## 12. MAIDEN NAME OF MOTHER

Martha Helneke

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo. R. Proctor  
Hamper Ida

## 15.

Filed

Oct. 30, 1922 Pearl Dodge  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Oct. 17  
(Month)

(Day)

1922  
(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Oct. 17, 1922 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Born dead - due to  
Hydrocephalus  
(Duration) 1 Yrs. 2 mos. 2 ds.Contributory  
(Secondary)(Duration) 1 Yrs. 2 mos. 2 ds.

(Signed)

Geo. R. Proctor M. D.  
Hamper  
(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 Yrs. 2 mos. 2 days. In the State 1 Yrs. 2 mos. 2 days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Hamper

## DATE OF BURIAL

Oct. 17, 1922

## 20. UNDERTAKER

None

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

290-113-814-497  
PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED  
NOV 6 1922

CERTIFICATE OF BIRTH

S105608

County of Canyon

City of Nampa

No 603-18-25 St.

Registration District No. 7

File No.

Hospital

Primary Registration District No. 150

Registered No.

FULL NAME OF CHILD

not named (Stillborn)

Sex of Child	male	Twin Triplet or other?	<input checked="" type="checkbox"/>	and	Number in order of birth	<input checked="" type="checkbox"/>	Legitimate?	yes	Date of Birth	Sep-13	1922
		(To be answered only in event of plural births)							(Month)	(Day)	(Year)

FATHER  
FULL NAME James Kronick  
RESIDENCE 603-18<sup>th</sup> Ave S. Nampa  
COLOR White  
AGE AT LAST BIRTHDAY 36 (Years)  
BIRTHPLACE Greece  
OCCUPATION Cook

MOTHER  
FULL MAIDEN NAME Vida Dixon  
RESIDENCE 603-18<sup>th</sup> Ave S. Nampa  
COLOR White  
AGE AT LAST BIRTHDAY 28 (Years)  
BIRTHPLACE Wisconsin  
OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still Born at 3<sup>30</sup> A. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Geo W Chittum M.D.

(Physician or midwife)

Given names added from a supplemental report. 19

Address Nampa, Idaho

Filed Nov 6 1922 Pearl Dadds Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11-11-01 BY 60322 UCBAW/STP

NOTARY RECORDED FOR HUSBAND

Given names shall form a corresponding report.  
 Name of the child.  
 One that mother declares is a known other child.  
 midwife when the father, grandmother, etc.  
 What there was no other physician or

I hereby certify that I attended the birth of this child, who was  
 on the date specified.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

Number of child of this mother, including present birth.  
 Number of children of this mother, including present birth.

OCCUPATION		BIRTHPLACE		COLOR		AGE AT LAST BIRTHDAY		COLOR		RESIDENCE		FULL NAME	
FATHER		MOTHER		CHILD		CHILD		CHILD		CHILD		CHILD	
BIRTHPLACE		BIRTHPLACE		BIRTHPLACE		BIRTHPLACE		BIRTHPLACE		BIRTHPLACE		BIRTHPLACE	
AGE AT LAST BIRTHDAY		AGE AT LAST BIRTHDAY		AGE AT LAST BIRTHDAY		AGE AT LAST BIRTHDAY		AGE AT LAST BIRTHDAY		AGE AT LAST BIRTHDAY		AGE AT LAST BIRTHDAY	
COLOR		COLOR		COLOR		COLOR		COLOR		COLOR		COLOR	
RESIDENCE		RESIDENCE		RESIDENCE		RESIDENCE		RESIDENCE		RESIDENCE		RESIDENCE	
FULL NAME		FULL NAME		FULL NAME		FULL NAME		FULL NAME		FULL NAME		FULL NAME	

LAST NAME OF CHILD  
 FIRST NAME OF CHILD  
 SEX OF CHILD  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 COUNTY OF  
 STATE OF  
 CITY OF  
 DISTRICT OF  
 PRIMARY REGISTRATION DISTRICT  
 No. 11-11-01



# STATE OF IDAHO

## DEPARTMENT OF PUBLIC HEALTH

Boise, Idaho, .....

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

ED  
1922  
U OF VITAL  
STATISTICS

City *Pampa*  
Place of Birth {  
Street *18th ave*  
County *Canyon*

File Number *105608*

Registration Dist. No. ....

Sex of Child *Male* *yes*

Date of Birth *Sep 13* 192*2*

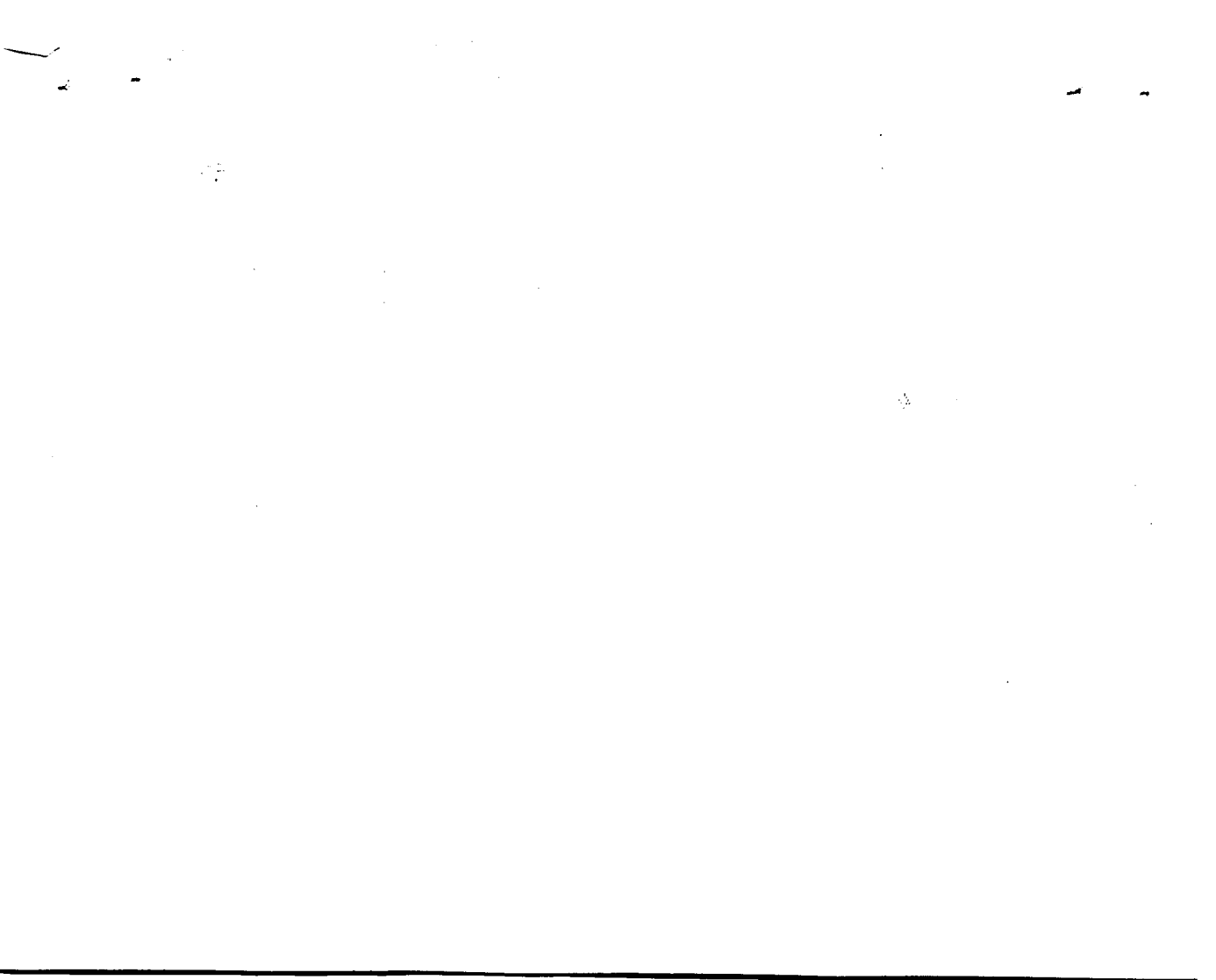
Father *James G. Kronicks*  
Full Name

Mother *Veda June Dixon*  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*James Junior Kronicks Still born baby*  
Child's Name in Full

*James G. Kronicks*  
Signature of Father or Mother



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS THAN 1 day  
how many ☒ hrs.  
or ☐ mts.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (for employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Nov. 6 1922

Local Registrar

Registration District No.

Primary Registration District No.

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Signed)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

719-117-014-155  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED

NOV 8 1922 CERTIFICATE OF BIRTH

S

105610

County of Canyon

City of Nampa

No. 520-19th & 8th St.

BUREAU OF VITAL STATISTICS  
Registration District No. 7

File No.

Hospital

Primary Registration District No. 7006

Registered No.

FULL NAME OF CHILD

Not named

(Certificate of no value without full name of child.)

Sex of Child

Male

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti-  
mate?

yes

Date of  
birth

Oct. 17

1922

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes?

Silver nitrate 1% Sol.

Number of child of this mother, including present birth

6

Number of child of this mother now living, including present birth

4

FULL  
NAME

FATHER

James E. Parks

RESIDENCE

Nampa - Idaho

COLOR

white

AGE AT LAST  
BIRTHDAY

46

(Years)

BIRTHPLACE

Texas

OCCUPATION

Miner

FULL  
MAIDEN  
NAME

MOTHER

Mary Overard

RESIDENCE

Nampa, Idaho

COLOR

white

AGE AT LAST  
BIRTHDAY

34

(Years)

BIRTHPLACE

Texas

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

born dead

at 10 P.

M.

on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

G. P. Proctor  
Physician

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed Nov. 6, 1922

Pearle Dodds

Registrar.

Registrar.

STATE OF

WEST VIRGINIA

1872

WILLIAM H. HARRIS

2nd of

to be

WILLIAM H. HARRIS

WILLIAM H. HARRIS

FROM

WILLIAM H. HARRIS

WILLIAM H. HARRIS

Doc. No. \_\_\_\_\_

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City .....  
                  { Street .....  
                  { County .....

File Number .....105610.....

Registration Dist. No. ....

Sex of Child.....~~Male~~.....

Date of Birth .....192....

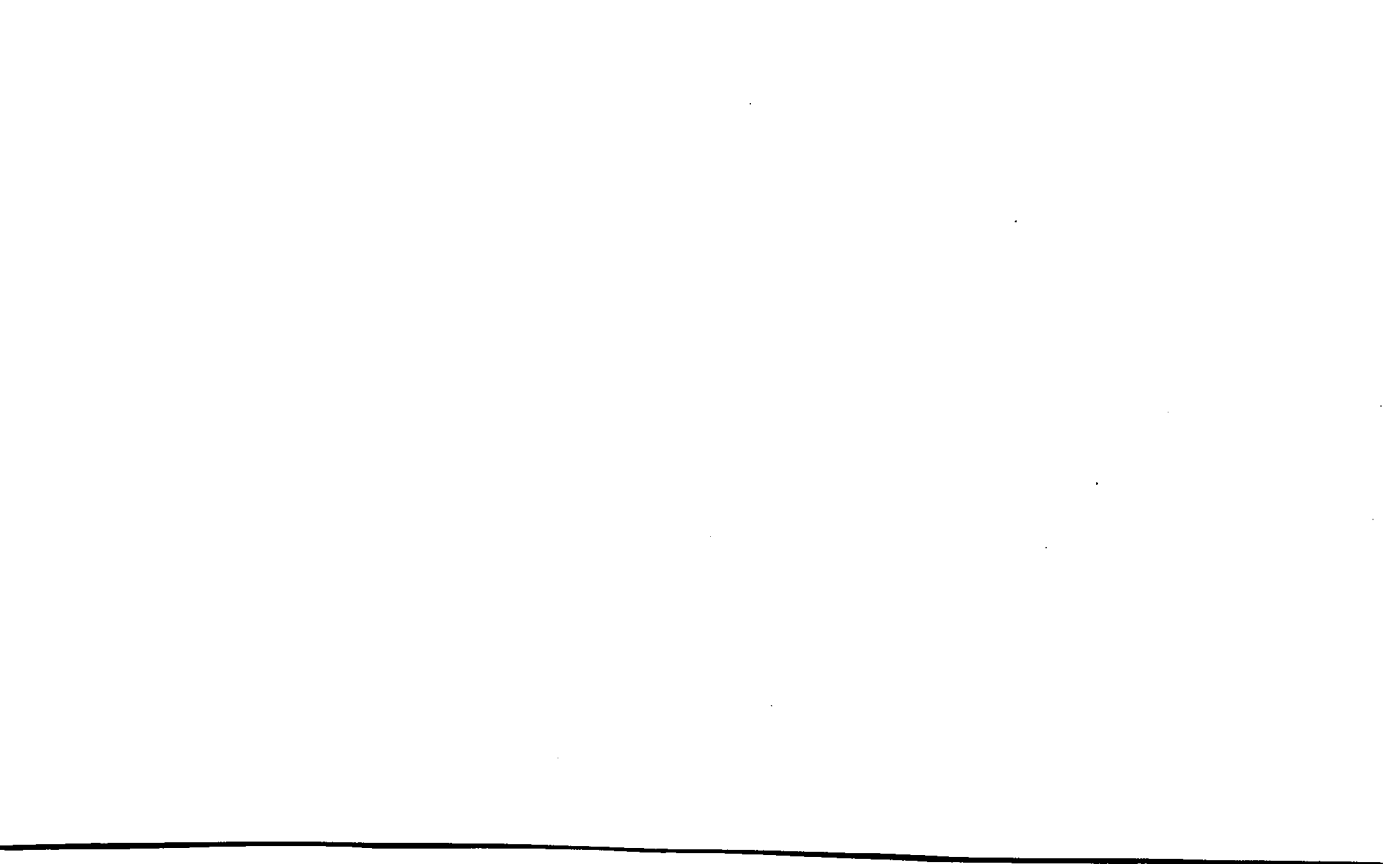
Father ..... Full Name

Mother ..... Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

.....  
Child's Name in Full

.....  
Signature of Father or Mother





WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## CERTIFICATE OF DEATH

State of Idaho  
BUREAU OF HEALTH  
Bureau of Vital Statistics  
39581  
File No.

## 1. PLACE OF DEATH

County of Damascus Registration District No. 7  
City of Nampa Primary Registration District No. 1006  
(No. 1006 St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Parks

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

Oct 17 1922  
(Month) (Day) (Year)

## 7. AGE

1 Yrs. 2 Mos. 2 da.

IF LESS than 1 day  
how many 1 hrs.  
or 1 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

none

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

James E. Parks

## 11. BIRTHPLACE OF FATHER

(State or Country)

Mont.

## 12. MAIDEN NAME OF MOTHER

Mary Overard

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Parks  
(Address) 520-15th Ave S. Nampa

## 15.

Filed Nov. 6 1922 Pearle Dadds  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Oct 17 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....  
that I last saw h..... alive on born dead,  
and that death occurred on the date stated above, at..... M.  
The CAUSE OF DEATH\* was as follows:

Ectocia

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) J. R. Crocker M. D.

19..... (Address) Nampa, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Hobbs Lane Cem

## DATE OF BURIAL

10-21-1922

## 20. UNDERTAKER

H. R. Robinson

## ADDRESS

Nampa

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

318-130-015-513  
PLACE OF BIRTH

STATE OF IDAHO  
RECEIVED DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

105613

County of Caribou NOV 5 1922  
City of \_\_\_\_\_  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 82 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2159 Registered No. 54

FULL NAME OF CHILD

Baby Taylor

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>✓</u> and { Number in order of birth <u>✓</u>	Legitimate? <u>✓</u>	Date of birth <u>Aug. 30</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? — Deneb

Number of child of this mother, including present birth... 2 Number of child of this mother now living, including present birth... 0

FATHER  
FULL NAME Leroy Taylor  
RESIDENCE Soda Springs, Idaho  
COLOR white AGE AT LAST BIRTHDAY 31 (Years)  
BIRTHPLACE Ore.  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Maud Eaton  
RESIDENCE Soda Springs, Ida.  
COLOR white AGE AT LAST BIRTHDAY 31 (Years)  
BIRTHPLACE Ore.  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... stillborn at 3:00 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Russell Tignor

(Physician or midwife)

Address

Soda Springs, Idaho

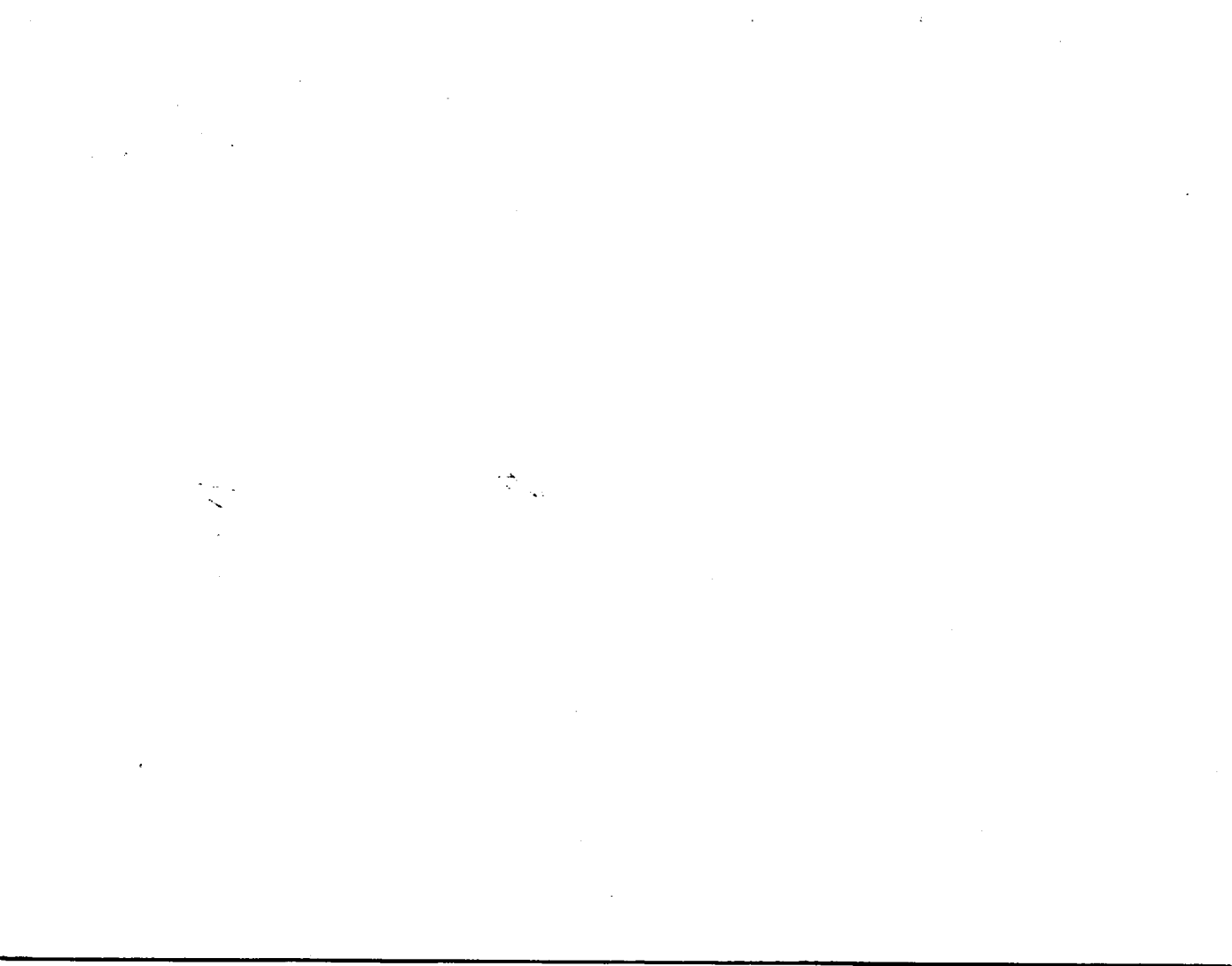
Filed

Oct 31 1922 Edw. K. K...

Registrar.

Give names added from a supplemental report.

Edw. K. K... 19...  
Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

439-121-016 419  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Cassia **NOV 4 1922**  
City of Basin **BUREAU OF VITAL STATISTICS**  
St. \_\_\_\_\_  
Registration District No. 120 File No. XXV111  
Hospital \_\_\_\_\_ Primary Registration District No. 2199 Registered No. 10

FULL NAME OF CHILD Unnamed (Stillborn)  
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>-</u> and <u>-</u> Number in order of birth <u>-</u>	Legitimate? <u>Yes</u>	Date of Birth <u>Sept 21</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	--	------------------------	---

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 1

FULL NAME <u>Sidney Ray McIntosh</u>	FATHER	FULL MAIDEN NAME <u>Marian Martin</u>	MOTHER
RESIDENCE <u>Basin</u>		RESIDENCE <u>Basin</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 3 de a M.  
on the date above stated. (Born alive or stillborn)

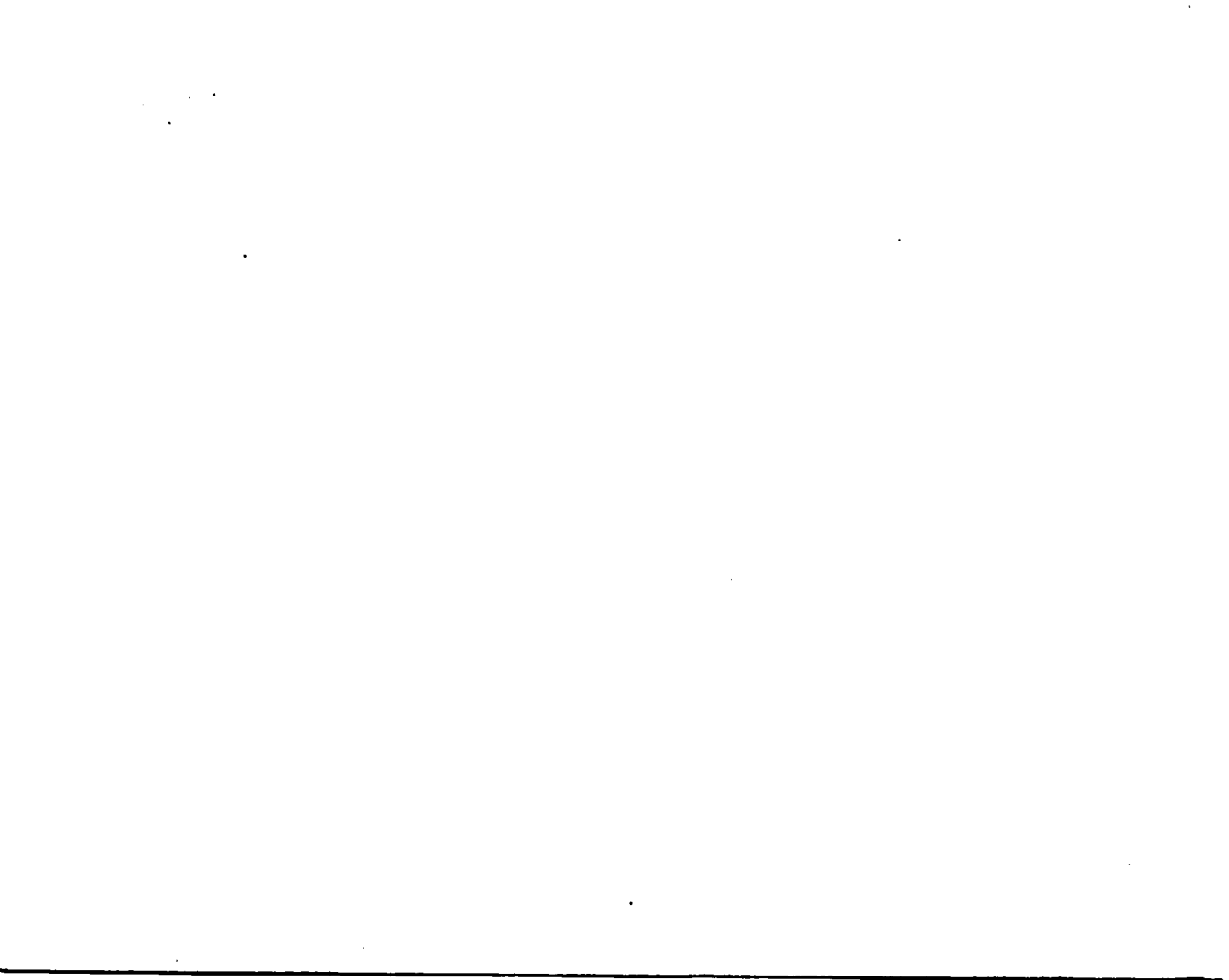
\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Jesse L. Hunsford

Give names added from a supplemental report.

Address Basin, Idaho

Filed Oct 31 1922 J. P. Stillborn  
Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

168-122-016-855  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 105649

County of Cassia St. Golden Valley Registration District No. 120 File No. XXVIII  
City of Golden Valley Primary Registration District No. 2499 Registered No. 12  
No. \_\_\_\_\_  
Hospital \_\_\_\_\_  
FULL NAME OF CHILD Unnamed (Stillborn)  
(Certificate of no value without full name of child.)

Sex of Child Male Twin Triplet - and - Number in order of birth - Legitimate? yes Date of birth Sept. 22 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FULL NAME <u>Nicholas Johnstone</u>	FATHER	FULL MAIDEN NAME <u>Carrie Henry</u>	MOTHER
RESIDENCE <u>Golden Valley</u>		RESIDENCE <u>Golden Valley</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Kansas</u>		BIRTHPLACE <u>Kansas</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 4:40 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Jose L. Rainard

Give names added from a supplemental report.

Address Cassidy, Idaho

Filed Oct. 3/1922

Registrar.

Registrar. W. O. Nielson

100000

Registration Number

Registration No.

Registration No.

Registration No.

Registration No.

Registration No.

Registration No.

Registration No.

Registration No.

Registration No.

Registration No.



955-107-020-238  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

County of ElmoreCity of Elmer's Ferry

No. \_\_\_\_\_

St. \_\_\_\_\_

Registration District No. 35File No. 105693

Hospital \_\_\_\_\_

Primary Registration District No. 2021

Registered No. \_\_\_\_\_

FULL NAME OF CHILD

unnamed

Sex of Child

maleTwin  
Triplet Smyle and  
or other \_\_\_\_\_  
(To be answered only in event of plural births)Number  
in order  
of birth3Legiti-  
mate?yesDate of  
BirthOct. 71922

(Month)

(Day)

(Year)

FULL  
NAMEFATHER  
William Ruben

RESIDENCE

Elmer's Ferry

COLOR

whiteAGE AT LAST  
BIRTHDAY42  
(Years)

BIRTHPLACE

Amnicia

OCCUPATION

RancherFULL  
MAIDEN  
NAMEMOTHER  
Mazana Blythe

RESIDENCE

Elmer's Ferry

COLOR

whiteAGE AT LAST  
BIRTHDAY34  
(Years)

BIRTHPLACE

Amnicia

OCCUPATION

HousewifeNumber of child of this mother, including present birth 3Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.Oct. 7, 1922 at 1:35 A M.  
(Base alive or stillborn)

(Signature)

J. W. Harris  
Physician

(Physician or midwife)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

Given names added from a supplemental report.

19

Address

Elmer's Ferry Idaho

Filed

Oct. 10 1922J. W. Harris

Registrar.

Registrar.

DISKING BEHOLD FOR HINDING  
 THIS IS A STATEMENT OF THE FACTS OF THE CASE AS STATED BY THE WITNESSES.  
 THE STATE OF NEW YORK  
 COUNTY OF NEW YORK  
 IN SENATE  
 JANUARY 1, 1911

PLACE OF BIRTH

DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF BIRTH

No. 102403

Primary Registration District No. 2021  
 Registered No.

Hospital  
 FULL NAME OF CHILD

SEX OF CHILD Male	DATE OF BIRTH 1910	PLACE OF BIRTH New York	FULL NAME OF FATHER [illegible]	FULL NAME OF MOTHER [illegible]
COLOR White	BIRTHDAY [illegible]	BIRTHPLACE New York	RESIDENCE [illegible]	RESIDENCE [illegible]
AGE AT LAST BIRTHDAY [illegible]	COLOR White	BIRTHPLACE New York	RESIDENCE [illegible]	RESIDENCE [illegible]
OCCUPATION [illegible]	OCCUPATION [illegible]	BIRTHPLACE New York	RESIDENCE [illegible]	RESIDENCE [illegible]

Number of child of this mother, living present birth 1  
 Number of children of this mother now living, including present birth 1  
 CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  
 I hereby certify that I attended the birth of this child, who was  
 [illegible]  
 (Signature)  
 (Physician or midwife)  
 Address  
 Filed

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact state-CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. ment of OCCUPATION is very important.

Form V. S. No. 5. 10M. 6-20-11.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **39625**

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. **35**  
County of **Elmore** Primary Registration District No. **2021**  
City of **Elmer's Ferry** (No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

**Unnamed**

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED. **Single**  
(Write the word.)

6. DATE OF BIRTH **Oct 7 1922**  
(Month) (Day) (Year)

7. AGE **Still Born** IF LESS than 1 day  
how many \_\_\_\_\_ hrs. or  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ min.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work **none**  
(b) General nature of industry business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

**America**

## 10. NAME OF FATHER

**William Ruebner**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Am.**

## 12. MAIDEN NAME OF MOTHER

**Margann - Blythe**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Am**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**William Ruebner**

(Address)

**Elmer's Ferry Idaho**

15.

Filed **Oct 8 1922****J. W. Jones**

Local Registrar

MEDICAL CERTIFICATE OF DEATH **189-b**

## 16. DATE OF DEATH

**Oct 6 1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 6 1922**, to **Oct 6 1922**, that I last saw him alive on **Oct 6 1922**, and that death occurred on the date stated above, at **12 M.**

The CAUSE OF DEATH\* was as follows:

**Difficult labor**

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) **J. W. Jones** M. D.**Oct 7 1922** (Address) **Elmer's Ferry Idaho**

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Elmer's Ferry Idaho****Oct 9 1922**

## 20. UNDERTAKER

## ADDRESS

**Joe Ruebner Elmer's Ferry Idaho**

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

655-202-027-854  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Franklin  
City of Weston, Idaho.  
No. 119 Flowers Court Registration District No. 27 File No. 105707  
Hospital Salt Lake City. Primary Registration District No. 2119 Registered No. 282

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>    </u> { and } Number in order of birth <u>    </u>	Legitimate? <u>Yes.</u>	Date of birth <u>Oct. 2,</u> 192 <u>2</u> (Month) (Day) (Year)
----------------------------	---	-------------------------	---

(To be answered only in event of plural births)

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FULL NAME <u>C. E. Weed</u> FATHER	FULL MAIDEN NAME <u>Anna Heusser</u> MOTHER
RESIDENCE <u>Weston, Idaho.</u>	RESIDENCE <u>Weston, Idaho.</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Oneonta N.Y.</u>	BIRTHPLACE <u>Salt Lake City. Utah.</u>
OCCUPATION <u>Electrical Contractor</u>	OCCUPATION <u>Housewife.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Born Dead at 11:30 A. M.  
on the date above stated. (Born alive or stillborn)

{ \*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Signature)

G. W. States  
Physician

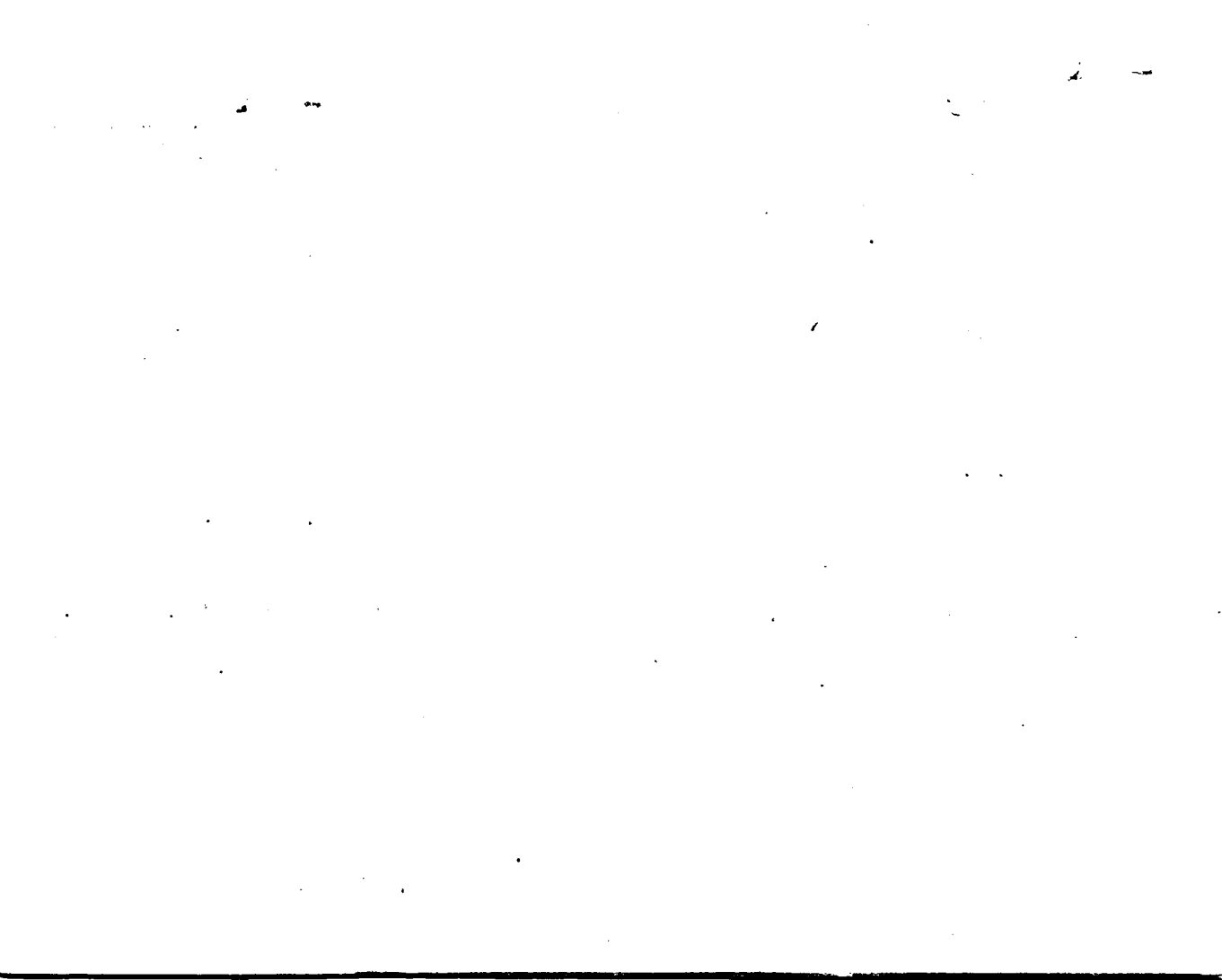
(Physician or midwife)

Give names added from a supplemental report.

Address Preston, Idaho.

Filed Nov. 2 1922 Mrs Ida Tippels  
Registrar.

Registrar.



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. **RECEIVED**  
Registration District No. 27  
County of Franklin **NOV 8 1922**  
Primary Registration District No. 2119  
City of Weston (No.        St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **39629**  
Registered No. 58  
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.         
(Write the word.)

6. DATE OF BIRTH Oct 2 1922  
(Month) (Day) (Year)

7. AGE Born dead IF LESS than 1 day  
yrs. mos. ds. how many hrs. or min?

8. OCCUPATION ✓  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Weston Idaho  
(State or Country)

10. NAME OF FATHER C. E. Reed

11. BIRTHPLACE OF FATHER Oneonta - N.Y.  
(State or Country)

12. MAIDEN NAME OF MOTHER Anna Neusser

13. BIRTHPLACE OF MOTHER Salt Lake City Utah  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant)         
(Address)       

15. Filed Nov. 2 1922 Mrs Ida Lyngels  
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 2 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1922 to Oct 2 1922  
that I last saw her alive on Born dead 1922  
and that death occurred on the date stated above, at        M.

The CAUSE OF DEATH\* was as follows:

Complications of childbirth  
(Duration) ✓ yrs. ✓ mos. ✓ ds.

Contributory (Secondary)         
(Duration) ✓ yrs. ✓ mos. ✓ ds.  
(Signed) G. W. States M. D.  
19 (Address) Preston Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death        yrs.        mos.        ds. State        yrs.        mos.        ds.  
Where was disease contracted,  
If not at place of death?  
Former or  
usual residence       

19. PLACE OF BURIAL OR REMOVAL Weston Idaho DATE OF BURIAL Oct 3 1922

20. UNDERTAKER        ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



275-214023-239  
PLACE OF BIRTHCounty of SenCity of Sweet

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

Full Name of Child

RECEIVED  
NOV 8 1927STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-25m-4-15-18

S 05752  
10575Registration District No. 6

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

SEX OF CHILD female Twin Triplet or other? \_\_\_\_\_ {and} Number in order of birth \_\_\_\_\_ Legitimate? yes DATE OF BIRTH Oct 14 1927  
(To be answered only in event of plural births)FULL NAME Herbert Spencer FATHERRESIDENCE SweetCOLOR white AGE AT LAST BIRTHDAY 25 (Years)BIRTHPLACE IowaOCCUPATION employed in motor pictureFULL MAIDEN NAME Michael Stiller MOTHERRESIDENCE Sweet IdahoCOLOR white AGE AT LAST BIRTHDAY 23 (Years)BIRTHPLACE IowaOCCUPATION house wifeNumber of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was S. Treeborn at 12:02 M on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) A. S. Reed, M.D.

Given names added from a supplemental report.

(Physician or midwife)

Address Emmett IdahoFiled 10/14 1927 J. D. Reynolds Registrar

Registrar

Full Name of Owner

10

34

300

42

TEAL TA 32A  
YACHTING

204344

**MONDAY**

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DATE

**WENTON**

1004  
1005  
1006

**DOMSQUAN**

0000

1944-45

00-340109

NAME OF ATTENDING PHYSICIAN OR NURSE \_\_\_\_\_

(unclassified) (S)

[illegible]

**CONFIDENTIAL**

## STATE OF IDAHO

## Boise, Idaho,

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place  
of  
Birth

City

Sweet

File Number

105752

Registration Dist. No.

Sex of Child

**Female**

Date of Birth

Oct. 14

.1922

**Father**

**Full Name**

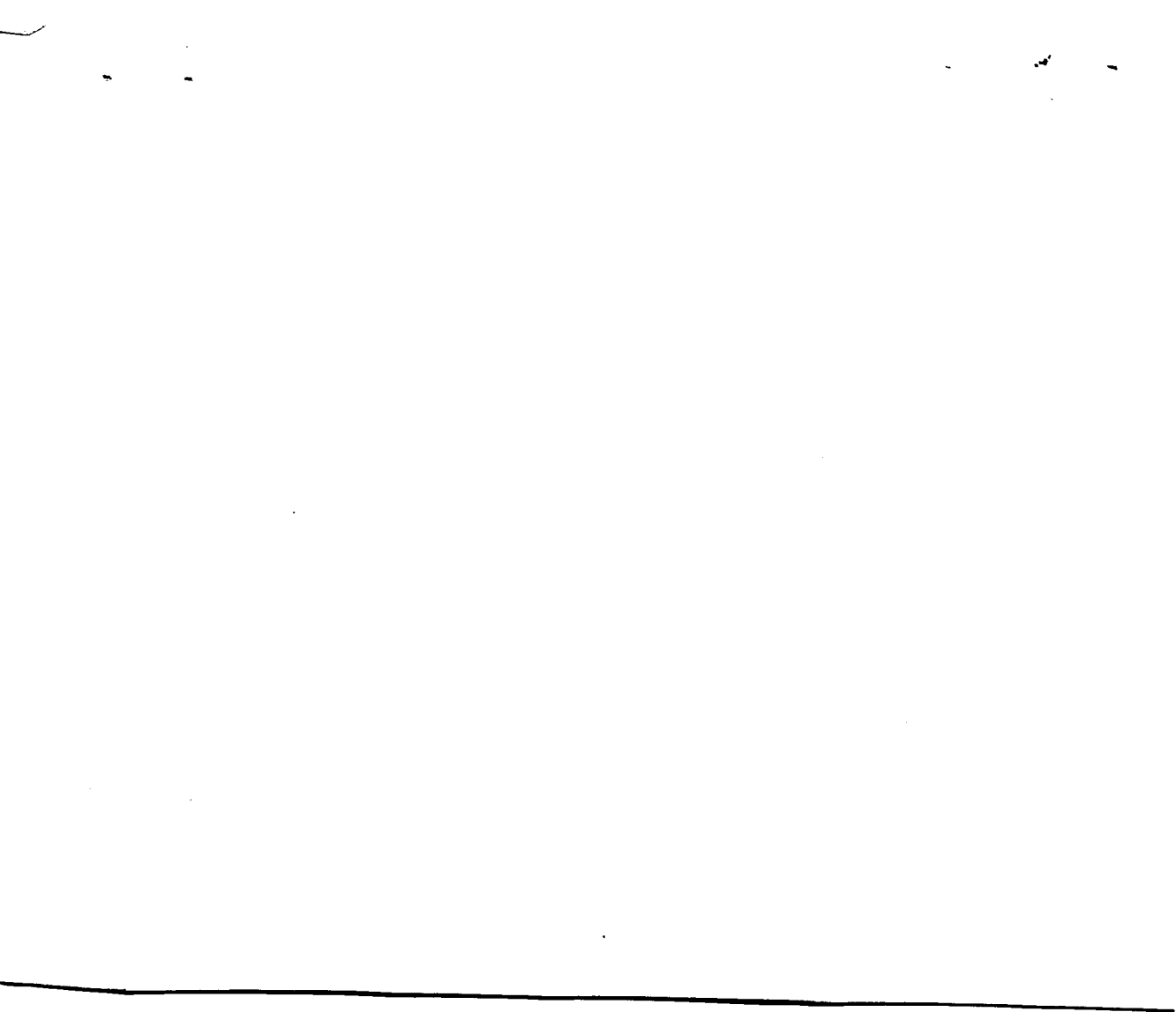
Mother

Full Maiden Name

I HEREBY CERTIFY that the child described herein has been examined.

Child's Name in Full

Signature of Father or Mother



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **38636**  
Registered No. \_\_\_\_\_

1. PLACE OF DEATH  
County of Ben Registration District No. \_\_\_\_\_  
City of Sweet Primary Registration District No. \_\_\_\_\_  
City of \_\_\_\_\_ (No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Girl Spencer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant  
(Write the word.)

6. DATE OF BIRTH Oct 14 1922  
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day  
Yrs. Mos. da. how many X hrs.  
or Y min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work. \_\_\_\_\_  
(b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

9. BIRTHPLACE  
(State or Country) Sweet, Idaho

10. NAME OF FATHER H. D. Spencer

11. BIRTHPLACE OF FATHER  
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Michael Stiller

13. BIRTHPLACE OF MOTHER  
(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) A. G. O'Sullivan  
(Address) Emmett Idaho

15. Filed 10/14 1922 J. H. Reynolds  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 14 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1922 to 10/14 1922  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date stated above, at \_\_\_\_\_ M.  
The CAUSE OF DEATH\* was as follows:

Stillborn  
(Duration) \_\_\_\_\_ Yrs. mos. ds.  
Contributory (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. mos. ds.  
(Signed) A. G. O'Sullivan M. D.  
10/14 1922 (Address) Emmett Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death \_\_\_\_\_ yrs. mos. days. In the State \_\_\_\_\_ yrs. mos. days.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL Emmett Idaho DATE OF BURIAL 10/14 1922  
20. UNDERTAKER Ed. Buckner ADDRESS Emmett

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

296-102-025-449  
PLACE OF BIRTH

RECEIVED

OCT 24 1922

BUREAU OF VITAL STATISTICS

STATE OF IDAHO

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

105779

County of Idaho

City of Kooskia

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Registration District No. 106

File No. \_\_\_\_\_

Primary Registration District No. 2184

Registered No. 32

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of  
Child

Male

Twin  
Triplet  
or other?

Twins

and

Number  
in order  
of birth

2

Legiti-  
mate?

yes

Date of  
birth

Sept. 2, 1922

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 6

Number of child of this mother now living, including present birth... 6

FULL  
NAME

FATHER

Walter Brown

RESIDENCE

Clearwater

COLOR

White

AGE AT LAST  
BIRTHDAY

38

(Years)

BIRTHPLACE

Minnesota

OCCUPATION

Farmer

FULL  
MAIDEN  
NAME

MOTHER

Blanche Murphy

RESIDENCE

Clearwater

COLOR

White

AGE AT LAST  
BIRTHDAY

38

(Years)

BIRTHPLACE

Kansas

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was...  
on the date above stated.

Kooskia at 11:55 P. M.  
(Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

J. M. Verberknoss

(Physician or midwife)

Give names added from a supplemental report.

Address

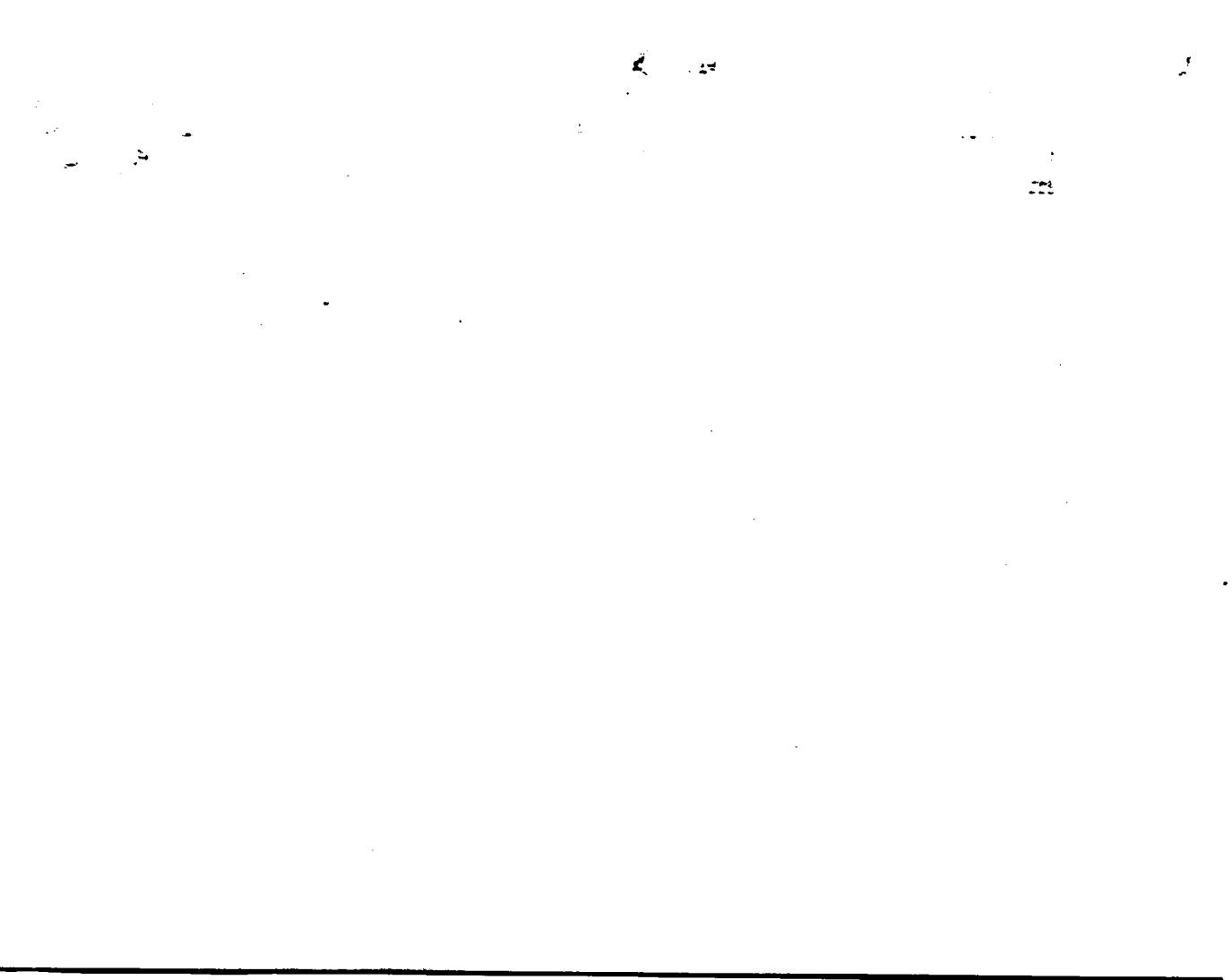
Kooskia - Idaho

Filed

Oct 1 1922

Registrar.

Registrar.





FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH

39645 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho RECEIVED  
City of Charley OCT 24 1922  
Registration District No. 106  
St. 2184File No. \_\_\_\_\_  
Registered No. 129If death occurs away from  
usual residence, give facts  
called for under special  
information.

2. FULL NAME

BUREAU OF VITAL  
STATISTICSStill birthIf death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.MaleWhiteSingle

(Write the word.)

6. DATE OF BIRTH.

Sept21922

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or  
min. 2

8. OCCUPATION

(a) Trade, profession or  
particular kind of work...  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which employ-  
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Charley Idaho10. NAME OF  
FATHERWalter Brown11. BIRTHPLACE  
OF FATHER

(State or Country)

Minnesota12. MAIDEN NAME  
OF MOTHERBlanche Murphy13. BIRTHPLACE  
OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Walter Brown

(Address)

Charley Idaho

15.

Filed

Sept 5 1922J. M. Verberkuers  
Local Registrar

16. DATE OF DEATH

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still birth -  
Forces had been dead for  
some time; Malaria.

(Duration)

Yrs.

mos.

ds.

Contributory  
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. M. Verberkuers

M. D.

Sept 4 1922 (Address) Kovicki - Idaho\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)  
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted  
if not at place of death?.....Former or  
usual residence .....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

CharleySept 3 1922

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

295-215-005-3148  
PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of Bennett

NOV 18 1922

CERTIFICATE OF BIRTH

City of St. Maris

BUREAU OF VITAL  
STATISTICS

32

S 106156

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2049

Registered No. 87

Hospital Home

FULL NAME OF CHILD

Baby Kendall

Sex of Child <u>female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes.</u>	Date of Birth <u>Oct. 15</u> 19 <u>22</u> (Month) (Day) (Year)
----------------------------	------------------------------	-----------	--------------------------------	-------------------------	---

FULL NAME <u>Samuel Kendall</u>	FATHER
RESIDENCE <u>St. Maris Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Nebraska</u>	
OCCUPATION <u>mill laborer</u>	

FULL MAIDEN NAME <u>Edith Kamsburg</u>	MOTHER
RESIDENCE <u>St. Maris, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Michigan</u>	
OCCUPATION <u>housewife</u>	

Number of child of this mother, including present birth 43 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

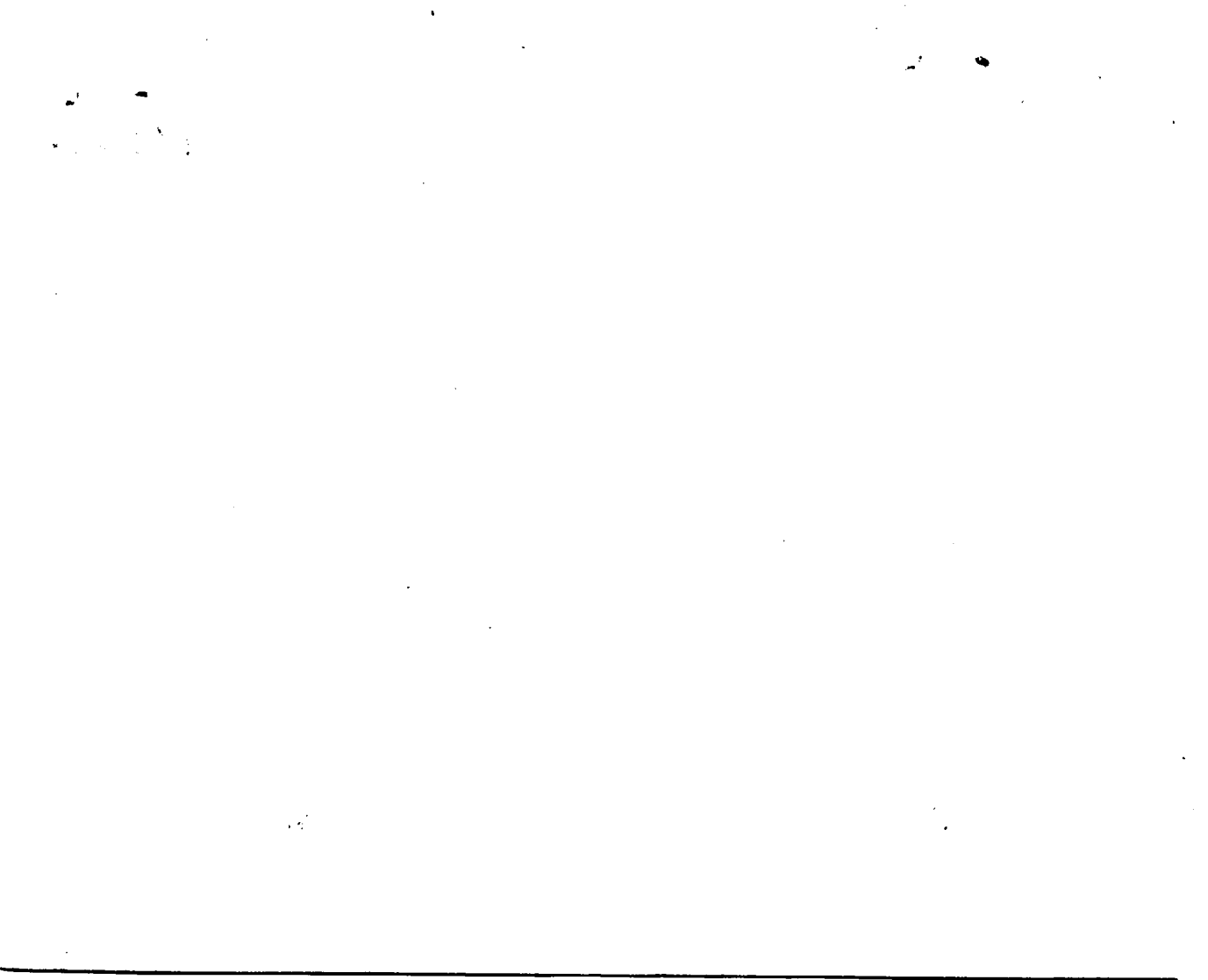
I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. B. Smith  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address St. Maris, Idaho  
Filed 10-17 1922 Oshurager  
Registrar



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. **39803**  
Registered No. **53**

1. PLACE OF DEATH **RECEIVED**  
 County of **Bennett** Registration District No. **32**  
 City of **St. Maries** Primary Registration District No. **2049**  
 (No.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Baby Kendall**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED **X**  
 (Write the word.)

## 6. DATE OF BIRTH

**Oct. 15, 1922**  
 (Month) (Day) (Year)

## 7. AGE

**Stillborn**

IF LESS than 1 day  
 how many hrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

**Idaho**

## 10. NAME OF FATHER

**Lammie Kendall**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Nebraska**

## 12. MAIDEN NAME OF MOTHER

**Edith Lamsburg**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Michigan**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Lammie Kendall**  
 (Address) **St. Maries, Ida.**

## 15.

Filed **10-17-22** **C. M. Mager**  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Oct. 15, 1922**  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

**Oct 15, 1922 to Oct 15, 1922**

that I last saw her alive on **Oct 15, 1922**

and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH\* was as follows:

**Still-born**

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

**Premature**

(Duration) yrs. mos. ds.

(Signed)

**C. B. Smith M. D.**

**10/16 1922** (Address) **St. Maries, Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

**Woodlawn**

## DATE OF BURIAL

**10-17-1922**

## 20. UNDERTAKER

**Mitchell & Murogan**

## ADDRESS

**St. Maries, Ida.**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

629-105-006-449

PLACE OF BIRTH

County of Bingham STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

City of Sterling CERTIFICATE OF BIRTH

Registration District No. 116 File No. S106167  
13

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2195 Registered No. 743

FULL NAME OF CHILD Evelyn O'Brien (Still born)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legiti mate? <u>yes</u>	Date of Birth <u>Oct 5</u> <u>22</u> (Month) (Day) (Year)
--------------------------	------------------------------------	-----------	---	----------------------------	---

FATHER  
FULL NAME Patrick J O'Brien  
RESIDENCE Sterling Ida  
COLOR White AGE AT LAST BIRTHDAY 30  
(Years)  
BIRTHPLACE Ireland  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Mary Margaret Murphy  
RESIDENCE Sterling Ida  
COLOR White AGE AT LAST BIRTHDAY 24  
(Years)  
BIRTHPLACE Ireland  
OCCUPATION Housewife

Number of child of this mother, including present birth. 1 Number of children of this mother now living, including present birth. 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 5:30 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

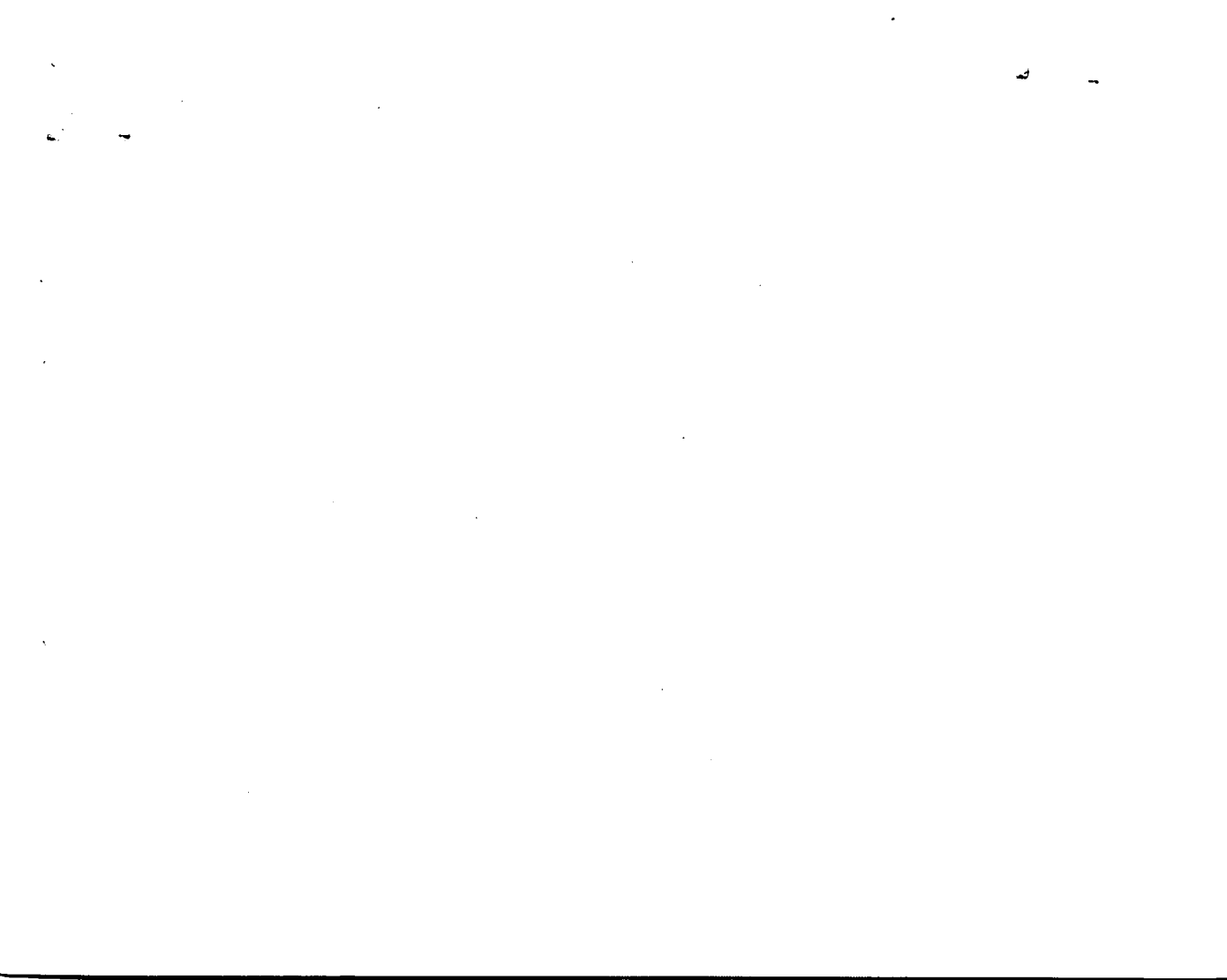
(Signature) M. C. MacKinnon M.D.  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Aberdeen Ida  
Filed Oct 5 22 MacKinnon  
19 \_\_\_\_\_

Registrar

Registrar





FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

39829

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Bingham  
City of StarlingRegistration District No. 116Statistical District No. 2195(No. STATISTICAL)File No. 4Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Gerald O'Brien (Stillborn)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single  
(Write the word.)

## 6. DATE OF BIRTH

Oct 5 1922  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Patrick J O'Brien

## 11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

## 12. MAIDEN NAME OF MOTHER

Mary M Murphy

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

P. J. O'Brien  
Starling Ida

## 15.

Filed

Oct 5 - 22 McMannin  
19

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Oct 5 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19  
that I last saw h. alive on 19  
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Still birth -  
Premature birth

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

McMannin M. D.  
Oct 5 - 22 Starling Ida  
19 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Yuma IdaOct 6 1922

## 20. UNDERTAKER

## ADDRESS

McMannin-

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

275-115.008-275  
BIRTH

RECEIVED  
DEC 12 1922 DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Horse  
City of Grimes Pass  
Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
Primary Registration District No. 12 Registered No. 12

CERTIFICATE OF BIRTH **106211**

FULL NAME OF CHILD

Baby Spencer

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth... <u>Nov 15</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	---	---------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? .....

Number of child of this mother, including present birth... 1 Number of child of this mother now living, including present birth... 0

FULL NAME <u>Wm Spencer</u>	FATHER	FULL MAIDEN NAME <u>Wm Spencer</u>	MOTHER
RESIDENCE <u>Grimes Pass</u>		RESIDENCE <u>Grimes Pass</u>	
COLOR _____	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR _____	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>unknown</u>		BIRTHPLACE <u>unknown</u>	
OCCUPATION _____		OCCUPATION _____	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still born M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Grace Farrell  
(Physician or midwife)

Give names added from a supplemental report.

Address Pineville  
Filed Dec 1 1922 Mrs E. K. Robinson  
Registrar.

Mrs E. K. Robinson 19\_\_\_\_  
Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

962-10-008-962  
PLACE OF BIRTH

RECEIVED  
NOV 18 1922

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Berle  
City of Grimes Pass  
No. \_\_\_\_\_ St. \_\_\_\_\_

CERTIFICATE OF BIRTH

Registration District No. 12

File No. 106219

Hospital \_\_\_\_\_ Primary Registration District No. 12

Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Baby Ross

(Certificate of no value without full name of child.)

Sex of Child

Male

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti-  
mate?

yes

Date of  
birth

Oct 4 1922  
(Month) (Day) (Year)

(To be answered only in event of plural births)

(Month) (Day) (Year)

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth. 1

Number of child of this mother now living, including present birth. 1

FULL  
NAME

FATHER  
Henry Ross

FULL  
MAIDEN  
NAME

MOTHER  
Mary Ross

RESIDENCE

Grimes Pass

RESIDENCE

Grimes Pass

COLOR

White

AGE AT LAST  
BIRTHDAY

2.7  
(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

2.2  
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Payette

OCCUPATION

Laborer

OCCUPATION

House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE \*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

Still born  
(Born alive or stillborn)

M.

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature) \_\_\_\_\_

Mary Ross  
(Physician or midwife)

Give names added from a supplemental report.

Mrs. E. S. Robson, 19\_\_\_\_

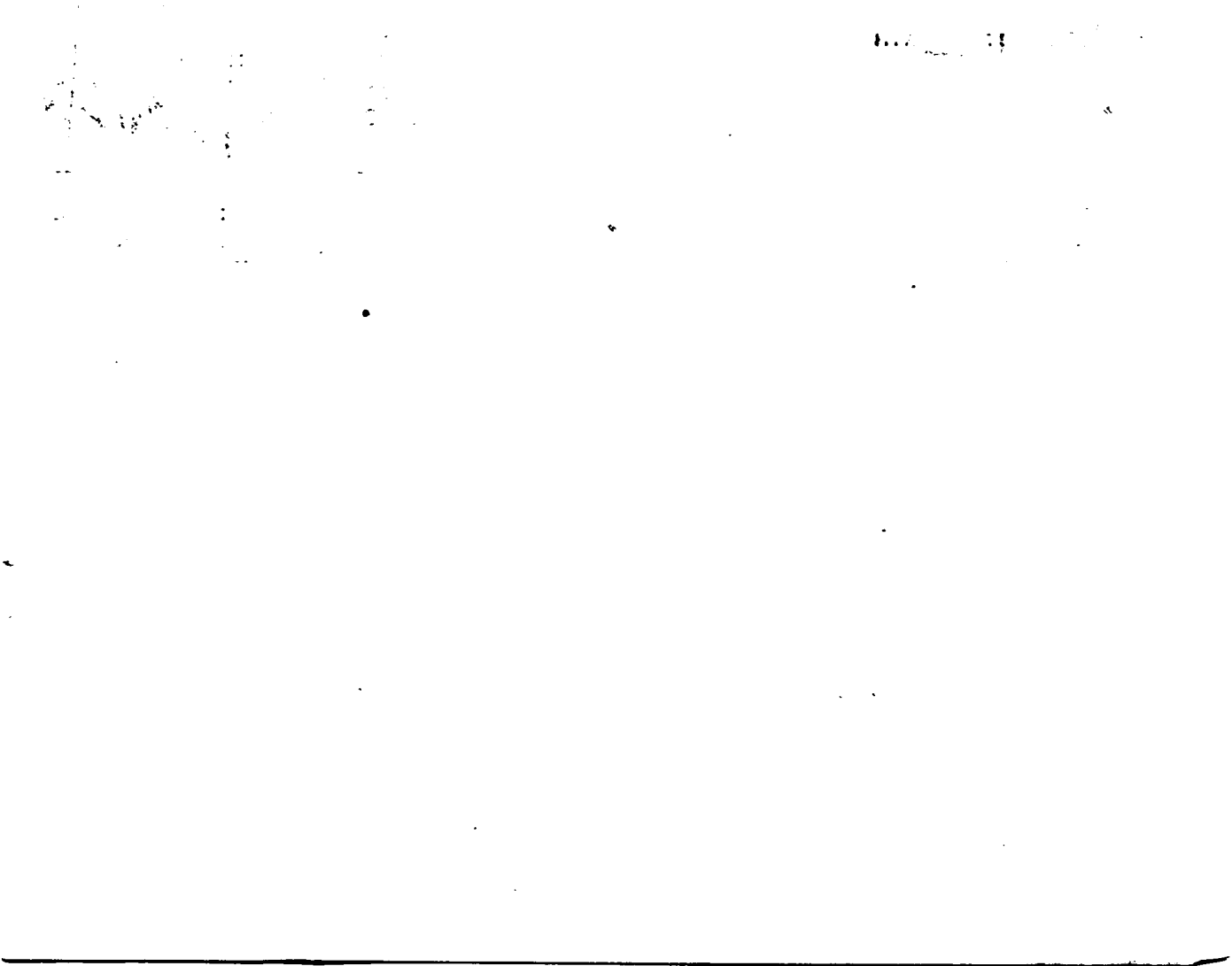
Registrar.

Address \_\_\_\_\_

Filed \_\_\_\_\_

Nov 1st 1922 Mrs. E. S. Robson

Registrar.



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

693-125-010-269

PLACE OF BIRTH

RECEIVED

NOV 16 1922

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-24-19

County of Bonneville

CERTIFICATE OF BIRTH  
STATISTICS

City of Neon

Registration District No. 73

File No. S 106258

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2100 Registered No. 246

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Wilkins

Sex of  
Child

Male

Twin  
Triplet  
or other?

—

and

Number  
in order  
of birth

—

Legiti  
mate?

Yes

Date of  
Birth

8  
(Month)

25  
(Day)

1922  
(Year)

FULL  
NAME

Reuben Wilkins

FATHER

RESIDENCE

Neon Idaho

COLOR

White

AGE AT LAST  
BIRTHDAY

43  
(Years)

BIRTHPLACE

Utah

OCCUPATION

Farmer

FULL  
MAIDEN  
NAME

Mary Lorensen

MOTHER

RESIDENCE

Neon - Idaho

COLOR

White

AGE AT LAST  
BIRTHDAY

40  
(Years)

BIRTHPLACE

Adger Utah

OCCUPATION

R. Wagon

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

Born dead  
(Born alive or stillborn)

at 6:00 A. M.

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

[Signature]

(Physician or midwife)

Given names added from a supplemental report.

19

Address

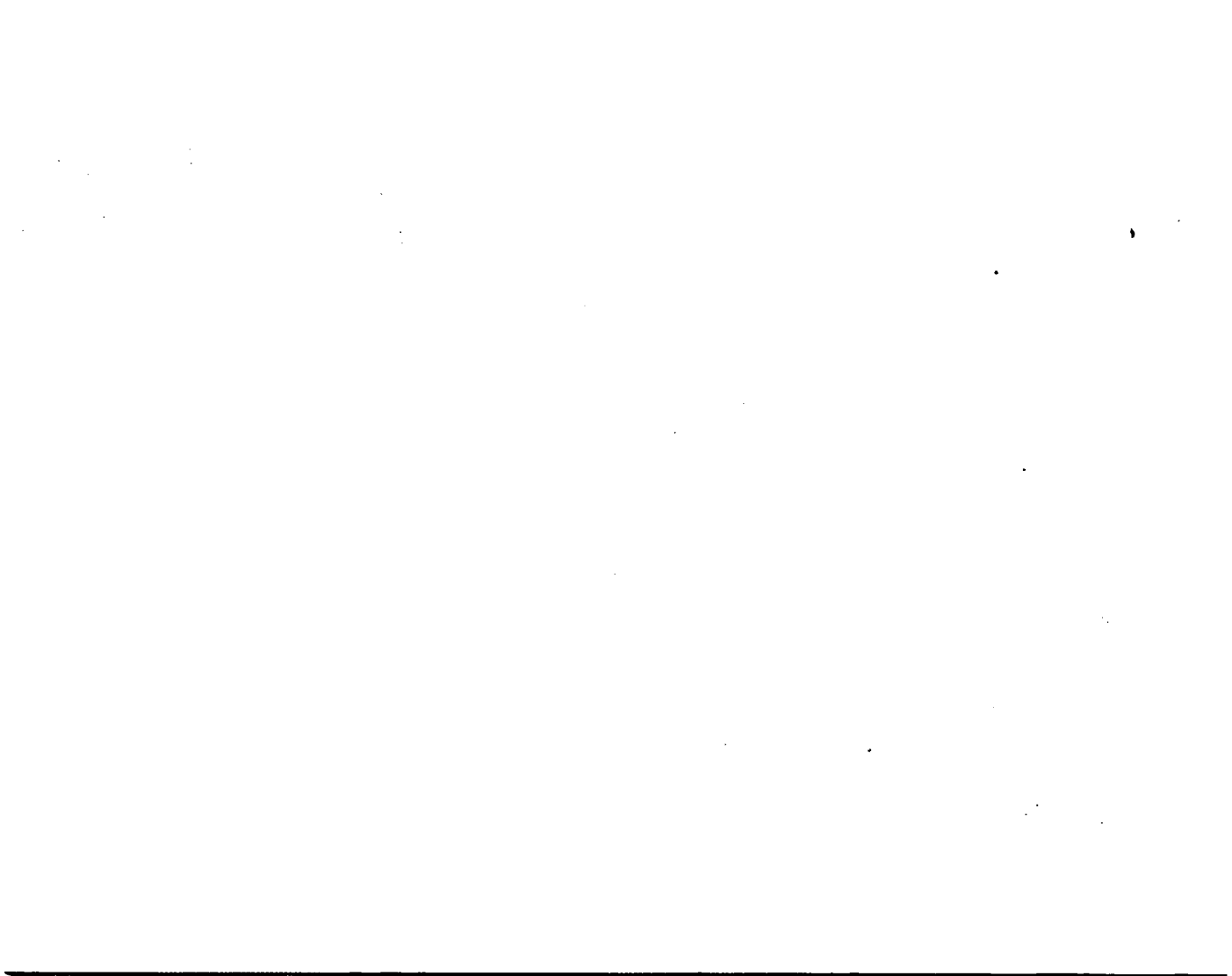
Scattergood, Jr.

Filed

Sept 11 - 1922

Registrar

Registrar





WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated. This certificate must be filed by the attending physician or midwife with the local registrar within 10 days after birth.

POSTOFFICE ADDRESS OF MOTHER

943-230-014-731

State Board of Health, Division of Vital Statistics

# CERTIFICATE OF BIRTH

State Registered No. **106391**

Local Registered No. **87**

## 1. PLACE OF BIRTH—

County Curry

State of Oregon

Township

or Village

City

No. 5 mi. N. W. St.

(If birth occurred in a hospital or institution, give its name instead of street and number)  
(If in country, give distance and direction from nearest town)

## 2. Full name of child

Parker

If child is not yet named, make supplemental report, as directed

3. Sex of child

7

To be answered ONLY in event of plural births.

4. Twin, triplet or other

1

6. Legitimate?

Yes

7. Date of birth

Sept 30 1922 (Month, day, year)

5. Number, in order of birth

1

Full name

## 8. FATHER

Lollo Parker

Full maiden name

## 14. MOTHER

Emma Hager

9. Residence (Usual place of abode)

If nonresident, give place and State

Curry

15. Residence (Usual place of abode)

If nonresident, give place and State

Curry

10. Color or race

W

11. Age at last birthday

37

(Years)

16. Color or race

W

17. Age at last birthday

37

(Years)

12. Birthplace (city or place)

(State or country)

Idaho

18. Birthplace (city or place)

(State or country)

Idaho

13. Occupation

Farmer

Nature of industry

19. Occupation

Housewife

Nature of industry

20. Number of children of this mother (Taken as of time of birth of child herein certified and including this child.)

(a) Born alive and now living

2

(b) Born alive but now dead

0

(c) Stillborn

1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 7 p. m. on the date above stated.  
(Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Signature

J. J. Saragan, M.D.  
Physician  
(Physician or Midwife)

Given name added from a supplemental report

(Month, day, year)

Address

Nessa Cre

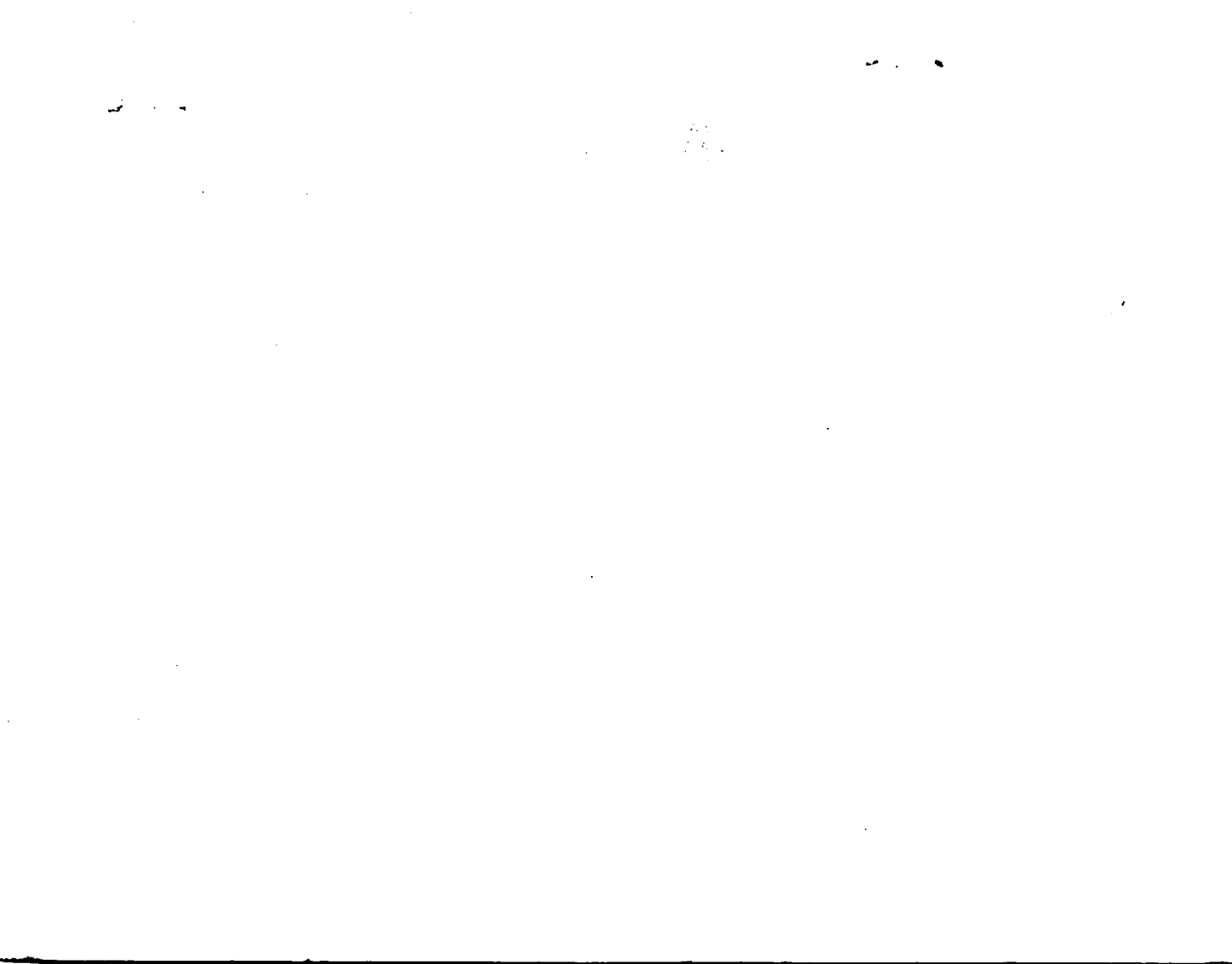
Filed

15, 1922

Sub. No. 106391

Registrar.

Registrar.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# OREGON STATE BOARD OF HEALTH

## CERTIFICATE OF DEATH

39592 7, issued  
burial permit  
John V. Meyer - Sec. Reg.  
State Registered No. ....  
Local Registered No. ....

1 PLACE OF DEATH  
County Tillamook Co State Ore. Local Registered No. ....  
Township Tillamook or Village 5 mi N.W. No. 5 mi N.W. St. Ward  
City Tillamook (If death occurred in a hospital or institution, give its name instead of street and number)  
2 FULL NAME Baby Tucker 1897  
(a) Residence. No. .... St. ....  
(Usual place of abode) (If nonresident, give city or town and state)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or divorced (write the word) Single

6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept. 30, 1922

7 AGE Years ✓ Months ✓ Days ✓ If less than 1 day, .... hrs. or .... min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ✓  
(b) General nature of industry, business, or establishment in which employed (or employer) ✓  
(c) Name of employer. ✓

9 BIRTHPLACE (city or town) Tillamook  
(State or country) 5 mi N.W.

10 NAME OF FATHER Rolls Tucker

11 BIRTHPLACE OF FATHER (city or town) Natr  
(State or country)

12 MAIDEN NAME OF MOTHER Emma Rogers

13 BIRTHPLACE OF MOTHER (city or town) Till  
(State or country)

14 Informant Rolls Tucker  
(Address) Tillamook, Ore.

15 Filed 1922, 19 1922 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1922 to Sept. 30, 1922 that I last saw him alive on Sept. 30, 1922, and that death occurred on the date stated above, at 5 mi N.W.

The CAUSE OF DEATH\* was as follows. Temperature detached ment of placenta

(duration) .... yrs., .... mos., .... days.

CONTRIBUTORY (Secondary) (duration) .... yrs., .... mos., .... days.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Sarazin, M. D.  
, 19 1922 (Address)

\* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lower Boise

20 UNDERTAKER Paul G. Lane

DATE OF BURIAL Oct 1, 1922  
ADDRESS Boise, Idaho

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Health Assn.)

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic services for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 days*; *Bronchopneumonia* (secondary), *10 days*. Never report mere symptoms of terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "In-

anition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably such*, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

395-213,016-3 19  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

106433

County of Cassia

City of Burley

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 117

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2196

Registered No. 2430

FULL NAME OF CHILD \_\_\_\_\_

Emma Oteleia Lind.

(Certificate of no value without full name of child.)

Sex of  
Child

Female

Twins  
Triplet  
or other?

} and {

Number  
in order  
of birth

Legiti-  
mate?

Yes

Date of  
birth

Nov. 13

1922

(To be answered only in event of plural births)

(Month) (Day)

(Year)

What bactericidal solution was used in eyes? None used

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FULL  
NAME

FATHER

Lawrence Frechief Lind

RESIDENCE

Junction Valley Utah

COLOR

White

AGE AT LAST  
BIRTHDAY

37

(Years)

BIRTHPLACE

Junction Valley Utah.

OCCUPATION

Farmer

FULL  
MAIDEN  
NAME

MOTHER

Sophia Oteleia Carlson

RESIDENCE

Junction Valley Utah

COLOR

White

AGE AT LAST  
BIRTHDAY

38

(Years)

BIRTHPLACE

Smadjecken Sweden

OCCUPATION

Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Born dead, at 4:00 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature) \_\_\_\_\_

Physician.

(Physician or midwife)

Give names added from a supplemental report.

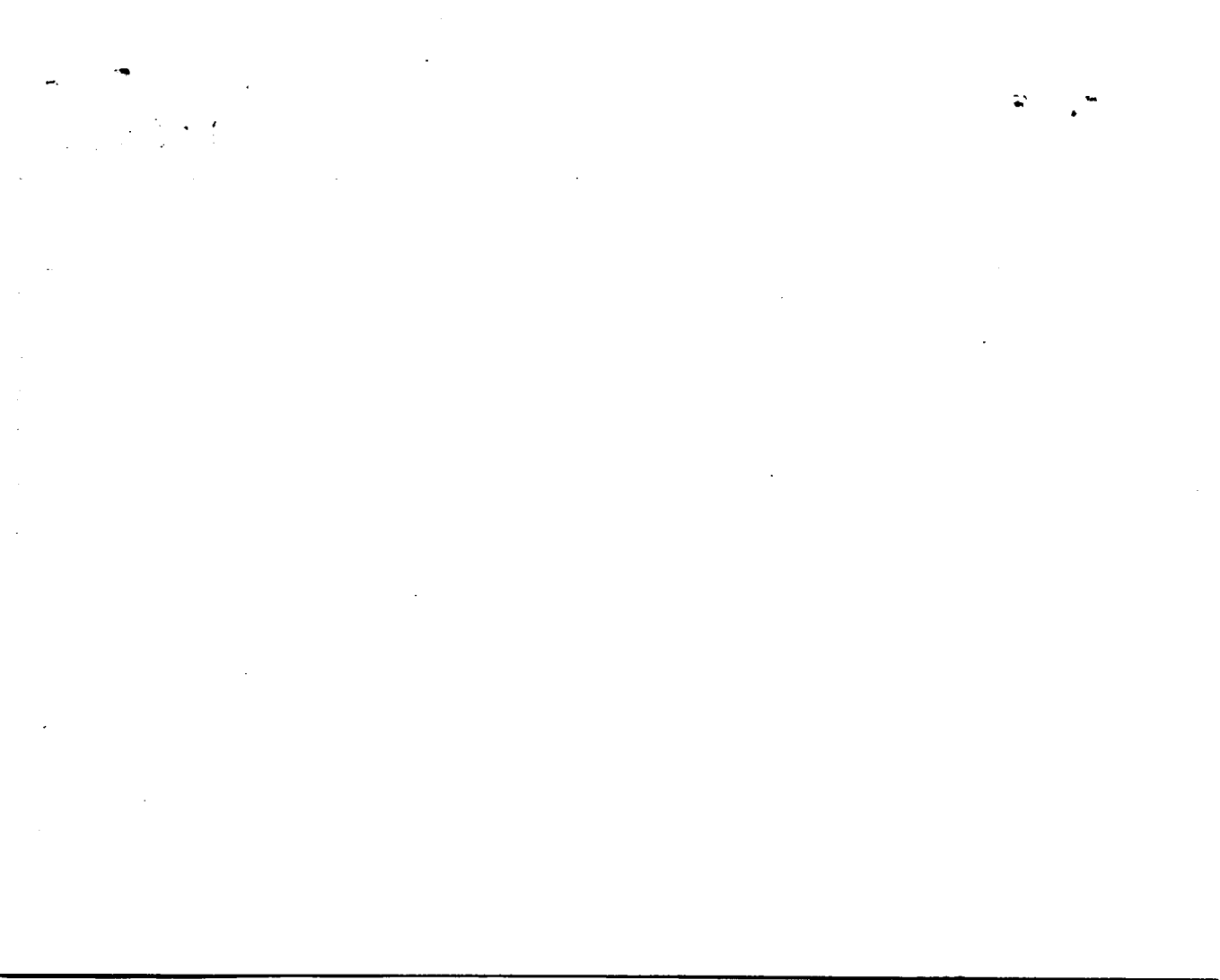
Address \_\_\_\_\_

Filed \_\_\_\_\_

Dec. 1 1922

Registrar.

Registrar.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Cassia  
City of BurleyRegistration District No. 117  
Primary Registration District No. 2196  
(No. \_\_\_\_\_ St.)File No. 39941  
Registered No. 638

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Emma Otelecia Lind

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

November 13 1922  
(Month) (Day) (Year)

## 7. AGE

Still birth  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)None

## 9. BIRTHPLACE

(State or Country)

Burley Ida.

## 10. NAME OF FATHER

Lawrence F. Lind

## 11. BIRTHPLACE OF FATHER

(State or Country)

Junction Valley U.

## 12. MAIDEN NAME OF MOTHER

Sophia Otelecia Carlson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Smedjebacken Sweden

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. F. Lind (per C. A. Rich)

(Address)

## 15.

Filed

Dec 1 1922 W. J. Patterson  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

November 13 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

The delivery on above  
date 11-13-22 and that death occurred on the date stated above, at \_\_\_\_\_ M.

## The CAUSE OF DEATH\* was as follows:

Still birth(Duration) Yrs. mos. ds.  
Contributory Abruptio Placentae  
(Secondary)(Duration) yrs. mos. ds.  
(Signed) C. A. Rich M. D.11-13-22 (Address) Burley Idaho.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Burley, Idaho

## DATE OF BURIAL

11-14 1922

## 20. UNDERTAKER

ADDRESS C

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



258-2091018-265

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-8-15

County of AdamsCity of Wippe

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

RECEIVED  
NOV 18 1922  
BUREAU OF VITAL  
STATISTICS

## CERTIFICATE OF BIRTH

File No.

106457

Primary Registration District No. 2168Registered No. 72

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth <u>Oct 9</u> 19 <u>22</u> (Month) (Day) (Year)
----------------------------	---	------------------------------------	-----------------------------	--

FULL NAME <u>Walter Baynes</u>	FATHER	FULL MAIDEN NAME <u>Harney Cannon</u>	MOTHER
--------------------------------	--------	---------------------------------------	--------

RESIDENCE <u>Wippe Ida</u>	RESIDENCE <u>Wippe Ida</u>
----------------------------	----------------------------

COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
--------------------	---	--------------------	---

BIRTHPLACE <u>W. Va.</u>	BIRTHPLACE <u>W. Va.</u>
--------------------------	--------------------------

OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>
---------------------------	-----------------------------

Number of child of this mother, including present birth <u>4</u>	Number of children of this mother now living, including present birth <u>3</u>
--	--

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5:00 P.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

File

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

NOV 15 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH. *Lebanon* District No. *90*  
County of *Lebanon* Primary Registration District No. *2168*  
City of *Whipple* (No. \_\_\_\_\_ St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *39954*  
Registered No. *53*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Shelburn*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *(Write the word.)*

6. DATE OF BIRTH

*October 9 1922*  
(Month) (Day) (Year)

7. AGE

*1* yrs. *1* mos. *1* ds.

IF LESS than 1 day  
how many \_\_\_\_\_ hrs. or  
\_\_\_\_\_ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*Walter Snyder*

11. BIRTHPLACE OF FATHER

(State or Country)

*W. Va*

12. MAIDEN NAME OF MOTHER

*Florence Cannon*

13. BIRTHPLACE OF MOTHER

(State or Country)

*W. Va*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Walter Snyder*

(Address)

*Whipple Ida*

15.

Filed

*Oct 9 1922 J. J. Gentry*  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*October 9 1922*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Oct 9 1922 to Oct 9 1922*

that I last saw him alive on *1922*

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

*Pneumonia - about 6 mo.*

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

*9/9 1922* (Address) *Dr. J. J. Gentry*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Whipple Ida*

*Oct 10 1922*

20. UNDERTAKER

ADDRESS

*none*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

255-130-020-315  
PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Elmore BUREAU OF VITAL STATISTICS

City of Elmer's Ferry

Registration District No. 36

File No. 106474

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2031

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Marmell Bentley

Sex of Child

male

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

1

Legiti-  
mate?

yes

Date of Birth

Nov. 30

1922

(Month) (Day) (Year)

FULL NAME

FATHER

Leonard Bentley

RESIDENCE

Elmer's Ferry Idaho

COLOR

white

AGE AT LAST BIRTHDAY

20

(Years)

BIRTHPLACE

Kansas

OCCUPATION

Laborer

FULL MAIDEN NAME

MOTHER

Maie Cavanagh

RESIDENCE

Elmer's Ferry Idaho

COLOR

white

AGE AT LAST BIRTHDAY

20

(Years)

BIRTHPLACE

Kansas

OCCUPATION

Housewife

Number of child of this mother, including present birth 1

Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ on the date above stated.

(Born ~~alive~~ or stillborn)

P M.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. W. Davis

Physician

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Elmer's Ferry Idaho

Filed

Nov. 30, 1922

J. W. Davis

Registrar.

Registrar.

STATE

OF

DEPT.

RECORDS

AND

COMMUNICATIONS

STATE OF IDAHO.  
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 12/16/22 1922.

Dear Madam:

The name of your baby was not filed in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

\* \* \* \* \*

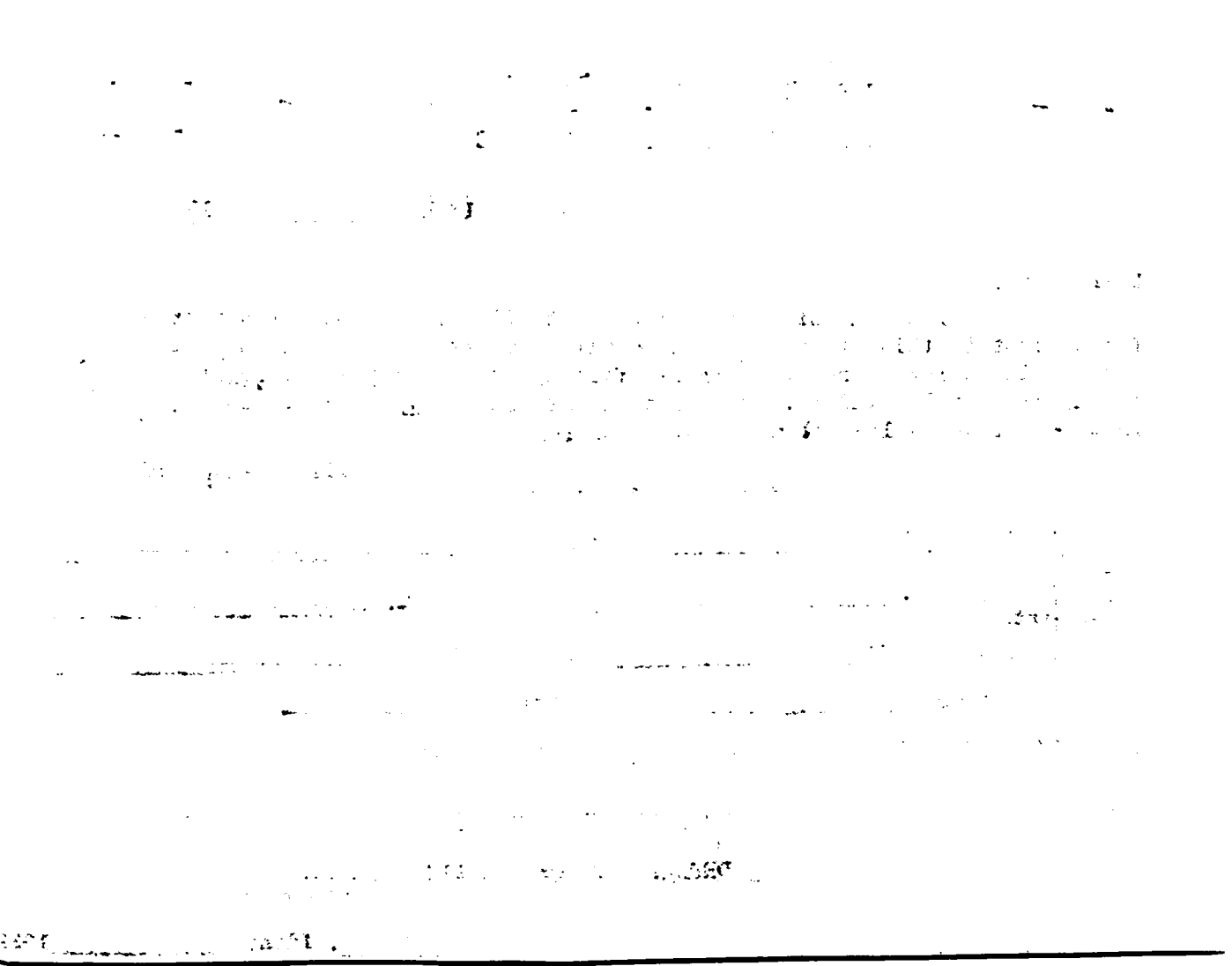
Place of Birth { City Glennville File No. 106474  
                  { St. \_\_\_\_\_ Date of Birth Nov 30 - 1922  
                  { County Claire Co Idaho Sex of Child Male  
Father Leonard M Bentley Mother Mal Bentley

I HEREBY CERTIFY that the child herein has been named:

Malwell Bentley

Leonard M Bentley

Signature of Father or Mother.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 10M. 6-20-11.

# CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **39963**

1. PLACE OF DEATH. **Elmore**  
County of **Elmore**  
City of **Elmore**  
Registration District No. **25**  
Bureau of Vital Statistics  
Registration District No. **2021**  
(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Unnamed**

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**  
(Write the word.)

6. DATE OF BIRTH **Nov 30 1922**  
(Month) (Day) (Year)

7. AGE **Still Born** IF LESS than 1 day  
hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work **none**  
(b) General nature of industry business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) **America**

## 10. NAME OF FATHER

**Donald Buntley**

## 11. BIRTHPLACE OF FATHER

(State or Country) **America**

## 12. MAIDEN NAME OF MOTHER

**Maie Cavanaugh**

## 13. BIRTHPLACE OF MOTHER

(State or Country) **America**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs Cavanaugh**

(Address) **Elmore, Idaho**

15.

Filed **Nov. 30 1922** **J. W. Doris**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

### 16. DATE OF DEATH

**Nov. 30 1922**  
(Month) (Day) (Year)

### 17. I HEREBY CERTIFY, That I attended deceased from

**Nov. 30 1922** to **Nov. 30 1922**

that I last saw him alive on **Still Born** 191

and that death occurred on the date stated above, at **12** M.

The CAUSE OF DEATH\* was as follows:

**Infant**

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. W. Doris** M. D.

**Nov. 30 1922** (Address) **Elmore, Idaho**

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

### 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

### 19. PLACE OF BURIAL OR REMOVAL

### DATE OF BURIAL

**Elmore, Idaho** **Nov. 1 1922**

### 20. UNDERTAKER

### ADDRESS

**Joe Rube** **Elmore, Idaho**

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

619-201020-236  
PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

106477

County of Elmore

City of Elmer's Ferry

No.                      St.                     

BUREAU OF VITAL

Registration District No. 35

File No.                     

Hospital                     

Primary Registration District No. 2021

Registered No.                     

FULL NAME OF CHILD

Unnamed

Sex of Child <u>Female</u>	Twin Triplet or other? <u>                    </u> (To be answered only in event of plural births)	and { Number in order of birth <u>4</u> }	Legitimate? <u>yes</u>	Date of Birth <u>Nov. 1</u> 1922 (Month) (Day) (Year)
----------------------------	---	---	------------------------	--

FATHER  
FULL NAME Alfred B. Warner  
RESIDENCE Elmer's Ferry Idaho  
COLOR White AGE AT LAST BIRTHDAY 42 (Years)  
BIRTHPLACE America  
OCCUPATION Cement man

MOTHER  
FULL MAIDEN NAME Alice Storey  
RESIDENCE Elmer's Ferry Idaho  
COLOR White AGE AT LAST BIRTHDAY 32 (Years)  
BIRTHPLACE America  
OCCUPATION Housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Nov. 1 1922 at 11 P. M.  
on the date above stated. (~~born~~ or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. W. Davis  
Physician  
(Physician or midwife)

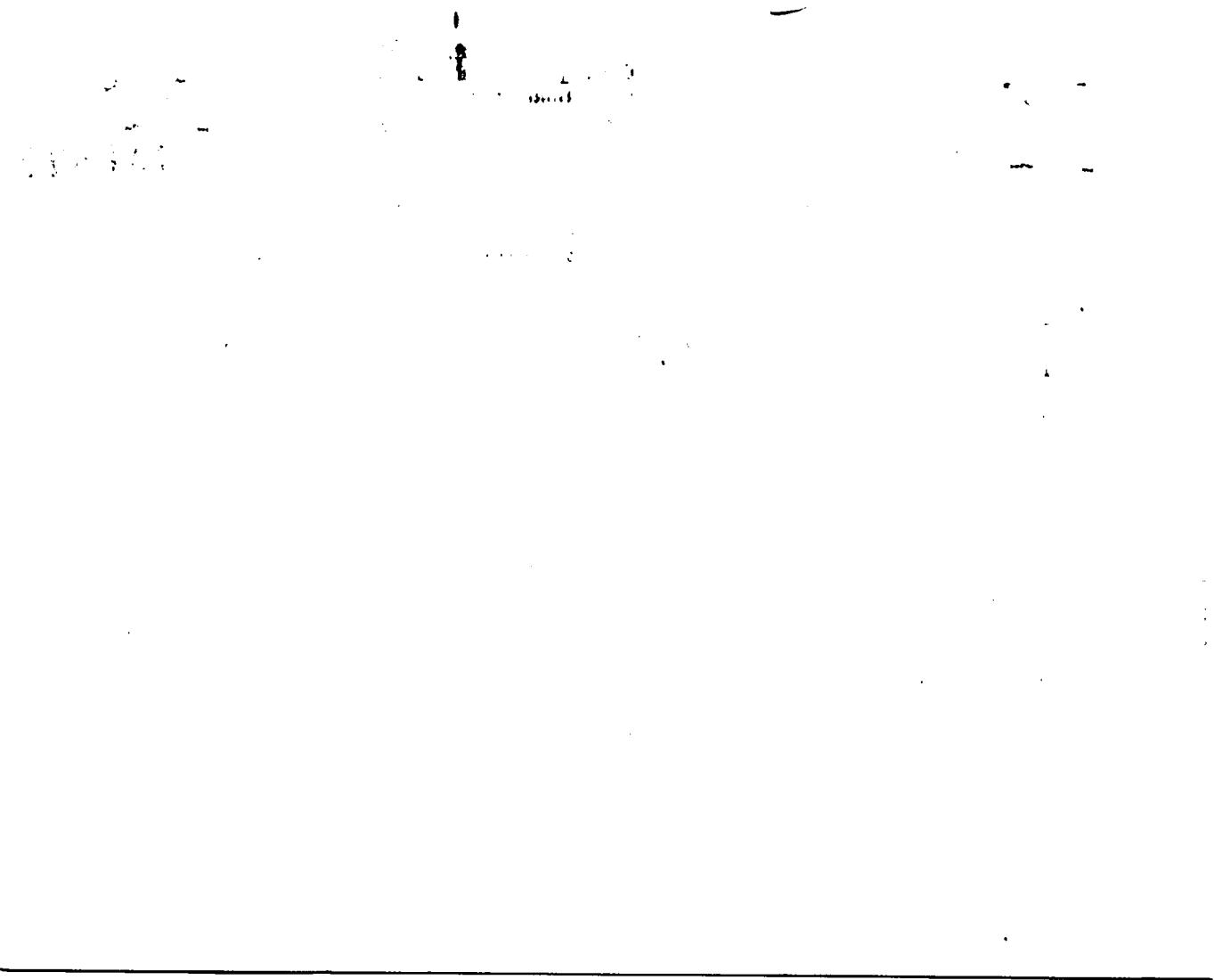
Given names added from a supplemental report.

Address Elmer's Ferry Idaho

Filed Nov 5 1922 J. W. Davis

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

# CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **39962**

1. PLACE OF DEATH.

Registration District No. **33**

County of **Elmore**

Primary Registration District No. **2021**

City of **Elmer's Ferry**

(No. **VITAL**)

St.)

Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

**Annamed**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

**Female** **White**

**Single**  
(Write the word.)

6. DATE OF BIRTH

**Nov.** **1<sup>st</sup>** **1922**  
(Month) (Day) (Year)

7. AGE

**Still Born**

IF LESS than 1 day  
how many **hrs.** or **min.**

8. OCCUPATION

(a) Trade, profession or particular kind of work **None**  
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Armenia**

10. NAME OF FATHER

**Will B Warner**

11. BIRTHPLACE OF FATHER

(State or Country) **Armenia**

12. MAIDEN NAME OF MOTHER

**Alice Story**

13. BIRTHPLACE OF MOTHER

(State or Country) **Colorado**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Will Warner**

(Address) **Elmer's Ferry Idaho**

15.

Filed **Nov 2nd** **1922** **J. W. Davis**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

**Nov.** **1<sup>st</sup>** **1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

**Nov. 1<sup>st</sup>** **1922**, to **Nov. 1<sup>st</sup>** **1922**

that I last saw h. **Still Born** **191**.,

and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH\* was as follows:

**Still Born**

(Duration) **yrs.** **mos.** **ds.**

Contributory **Toxaemia of mother**  
(Secondary) **Probably 24 weeks**

(Duration) **yrs.** **mos.** **ds.**

(Signed) **J. W. Davis** **M. D.**

**Nov. 2<sup>nd</sup>** **1922** (Address) **Elmer's Ferry Idaho**

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **yrs.** **mos.** **ds.** In the State **yrs.** **mos.** **ds.**

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

**Elmer's Ferry Idaho**

**Nov. 3<sup>rd</sup>** **1922**

20. UNDERTAKER

ADDRESS

**Will B. Warner** **Elmer's Ferry Idaho**

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

411-121-022-286

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of

## CERTIFICATE OF BIRTH

City of

Registration District No.

File No.

No.

St.

Primary Registration District No.

Registered No.

Hospital

FULL NAME OF CHILD

Sex of  
Child

M

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

{ and }

Number  
in order  
of birthLegiti  
mate?

yes

Date of  
Birth

Aug. 21

(Month) (Day)

19 22  
(Year)FULL  
NAMEFATHER  
Ed. MassFULL  
MAIDEN  
NAMEMOTHER  
Ethel Stormaker

RESIDENCE

St. Anthony

RESIDENCE

St. Anthony

COLOR

W

AGE AT LAST  
BIRTHDAY41  
(Years)

COLOR

W

AGE AT LAST  
BIRTHDAY37  
(Years)

BIRTHPLACE

Yamhill, S.D.

BIRTHPLACE

Cunningham, Ill.

OCCUPATION

Auto. Dealer

OCCUPATION

Housewife

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

(Born alive or stillborn)

at

M.

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

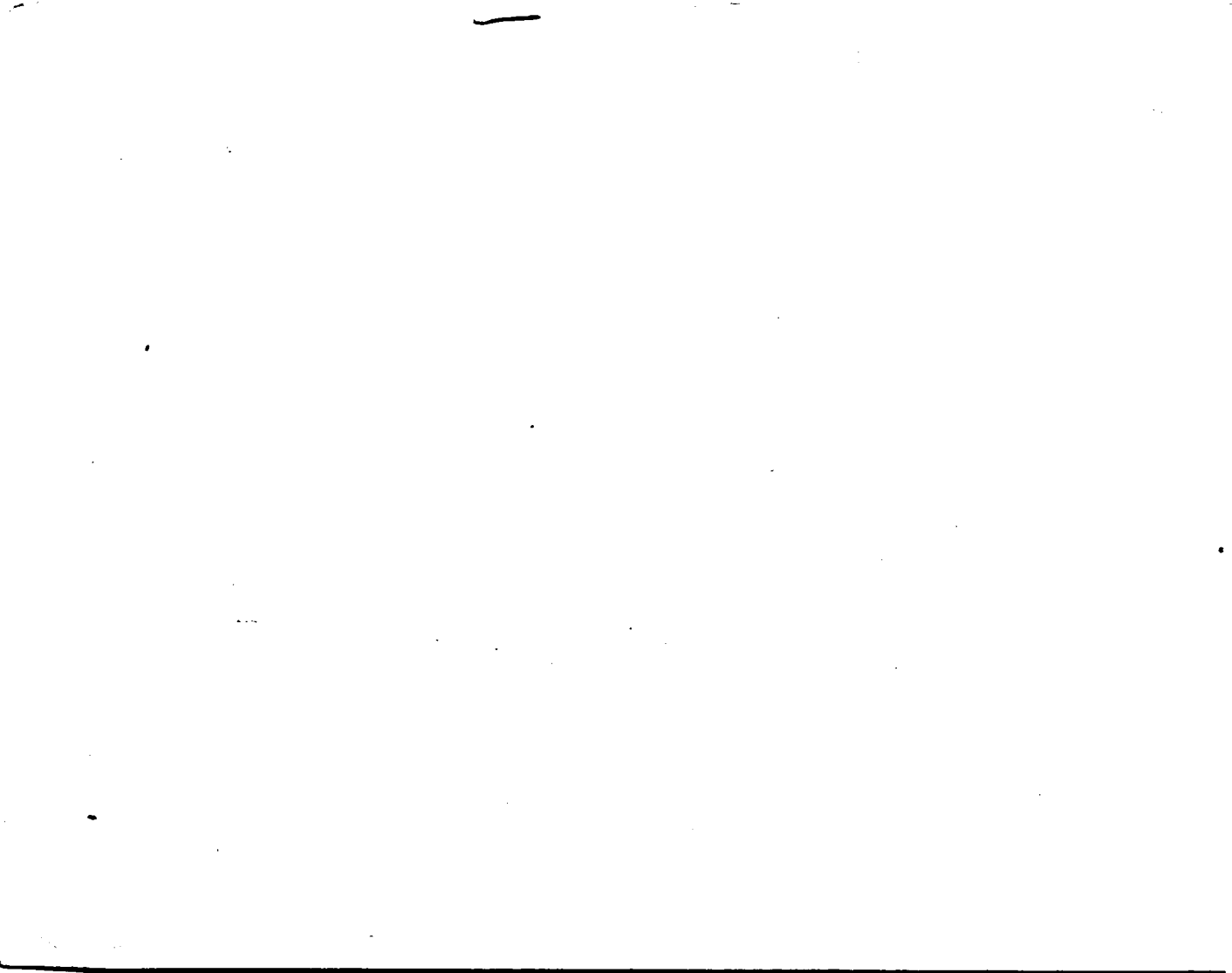
19 22

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.





WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

396-105-025-267

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of IdahoCity of CottonwoodBUREAU OF VITAL  
STATISTICS  
Registration District No. 105

CERTIFICATE OF BIRTH

S 106611

File No. 67

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2183

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

August Francis CrosbySex of  
ChildMaleTwin  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti  
mate?yesDate of  
BirthOct 5  
(Month) (Day)22  
(Year)FULL  
NAMEEnoch Crosby

FATHER

RESIDENCE

Cottonwood Ida.FULL  
MAIDEN  
NAMEMary Kapezynski

MOTHER

RESIDENCE

Cottonwood

COLOR

W.AGE AT LAST  
BIRTHDAY41  
(Years)

COLOR

W.AGE AT LAST  
BIRTHDAY41  
(Years)

BIRTHPLACE

Iowa

BIRTHPLACE

Kan.

OCCUPATION

Farmer

OCCUPATION

HousewifeNumber of child of this mother, including present birth 8Number of children of this mother now living, including present birth 4

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn,  
on the date above stated.

(Born alive or stillborn)

at 5 A. M.

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Dr. Wesley F. OrrCottonwood Ida.  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

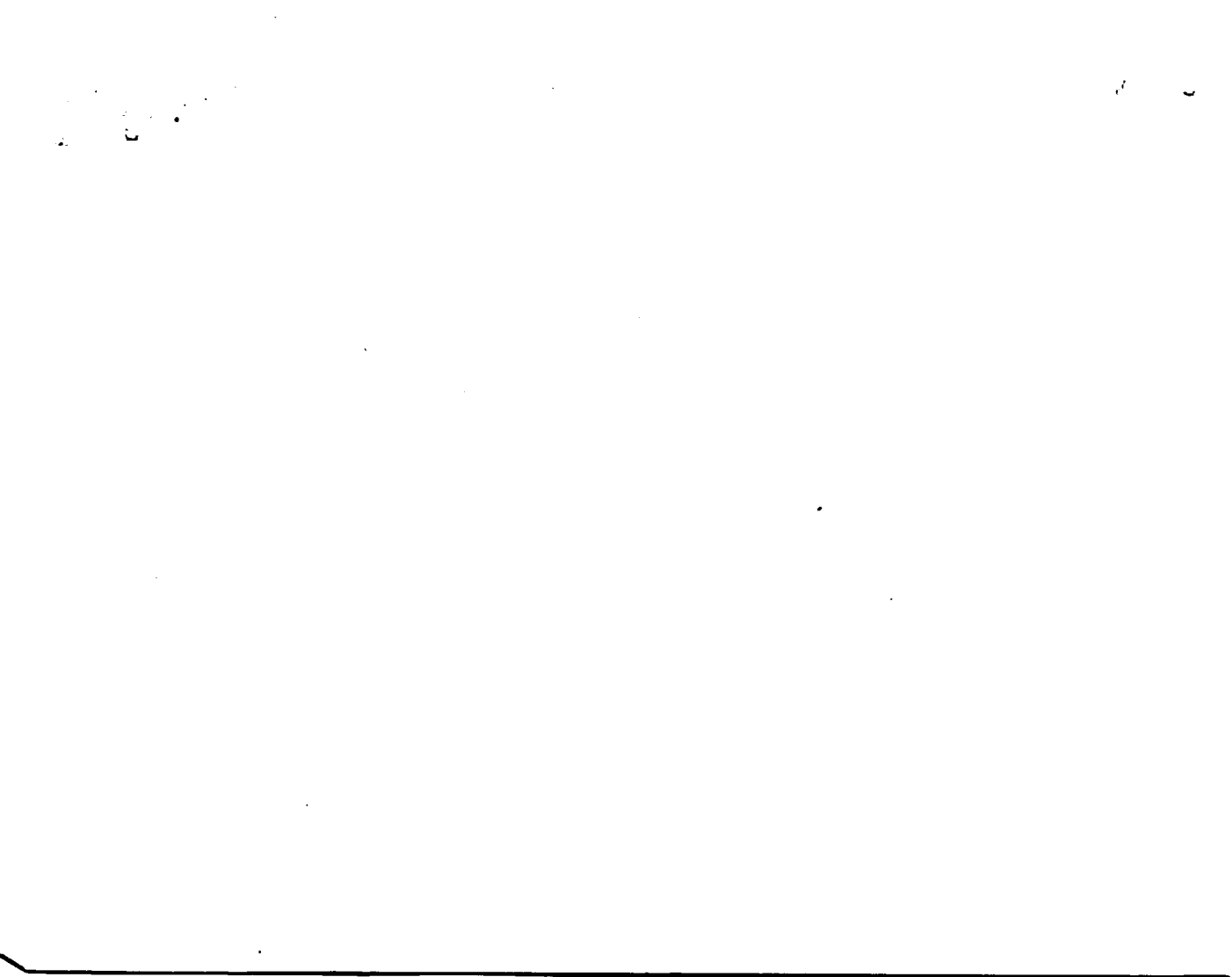
Cottonwood Ida.

Filed

Oct 30 1922W. F. Orr

Registrar

Registrar



FORM V. S. No. 5-25 M. 1-19.

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

STATISTICS

(No.)

103

2183

(St.)

40004

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

## 6. DATE OF BIRTH

## 7. AGE

If LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

## 17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to ..... 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

Version - Transverse Presentation

stillborn  
(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) Wesley F. Orr M. D.

Oct 30 1922 (Address) Cottonwood

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. .... mos. .... days. In the State..... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Cottonwood Ida. 10/5 1922

## 20. UNDERTAKER

## ADDRESS

Father Quack Crosby Cottonwood Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

389-113026-652  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICSCounty of Jefferson MAY 27 1922City of Grants

## CERTIFICATE OF BIRTH

Registration District No. 98

File No.

S 106643

No. \_\_\_\_\_ St.

Primary Registration District No. 2176Registered No. 289

Hospital \_\_\_\_\_

## FULL NAME OF CHILD \_\_\_\_\_

Sex of Child

mTwin  
Triplet  
or other?1stNumber  
in order  
of birth2ndLegiti-  
mate?YesDate of  
BirthNov 13 22

(Month) (Day) (Year)

FULL NAME

FATHER  
Marlin Christensen

FULL MAIDEN NAME

MOTHER  
Andella Webster

RESIDENCE

Grant

RESIDENCE

Grant

COLOR

WAGE AT LAST  
BIRTHDAY32  
(Years)

COLOR

WAGE AT LAST  
BIRTHDAY38  
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

at homeNumber of child of this mother, including present birth 5Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.Stillborn, at 2:10 P. M.  
(Born alive or stillborn)

(Signature)

J. C. Hollister

(Physician or midwife)

Given names added from a supplemental report.

19. \_\_\_\_\_

Address

Ida Falls

Filed

11-13-22 Ray H. Hinkle  
19. \_\_\_\_\_

Registrar.

Registrar.

543

## RECEIVED CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Jefferson Registration District No. 98  
 City of Grant (State of Idaho) St. 68

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 40012  
 Registered No. 68

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M W (Write the word.)

## 6. DATE OF BIRTH

Nov 13 1922  
 (Month) (Day) (Year)

## 7. AGE

Stillborn IF LESS than 1 day  
 how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Ida

## 10. NAME OF FATHER

Martin Christiansen

## 11. BIRTHPLACE OF FATHER

(State or Country) Utah

## 12. MAIDEN NAME OF MOTHER

A. Della Webster

## 13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martin Christiansen

(Address) Grant, Idaho

Filed Nov 13 1922 Ray Fisher  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Nov 13 1922  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH\* was as follows:

Stillborn  
7 mo.  
 (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Holbert M. D.

11-13-22 (Address) Ida Falls

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Grant 11-14 1922

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



389-113-026-652  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

S

County of JeffersonCity of GrantsRegistration District No. 98File No. 106644No. 2176Primary Registration District No. 288Registered No. 288

Hospital \_\_\_\_\_

FULL NAME OF CHILD ChristianSex of Child mTwin  
Triplet  
or other?  
(To be answered only in event of plural births)Number  
in order  
of birth1stLegitimate? yesDate of Birth Nov 13 22

(Month) (Day) (Year)

FULL NAME

FATHER

Martin Christian

FULL MAIDEN NAME

MOTHER

Ardella Webster

RESIDENCE

Grants

RESIDENCE

Grants

COLOR

W

AGE AT LAST BIRTHDAY

32  
(Years)

COLOR

W

AGE AT LAST BIRTHDAY

30  
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

at homeNumber of child of this mother, including present birth 4Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn on the date above stated.

(Born alive or stillborn)

M.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J.C. Hollister

Given names added from a supplemental report.

19.

Address

Ida. Falls

(Physician or midwife)

Filed

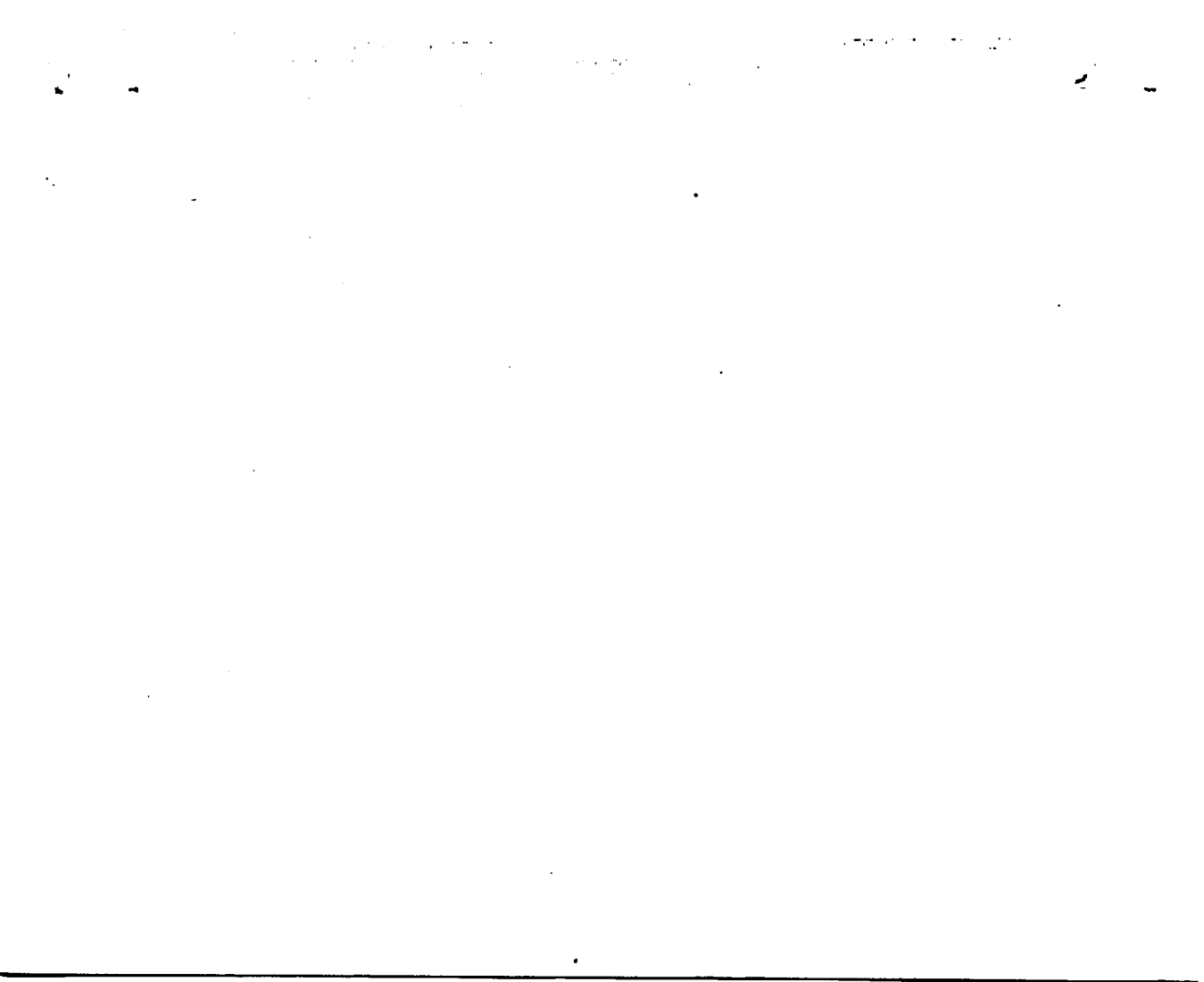
11-13

19.

22Ray Fisher

Registrar.

Registrar.



1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

## CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

719-281-028-25-2  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

106685

County of Kootenai

City of Coeur d'Alene

No. ✓ St. ✓

Registration District No. 30

File No. 106685

Hospital ✓

Primary Registration District No. 1051

Registered No. 1419

FULL NAME OF CHILD Mary Ellen Lavery

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>no</u> and Number in order of birth <u>one</u>	Legitimate? <u>yes</u>	Date of Birth <u>Aug 1 - 1922</u> (Month) (Day) (Year)
----------------------------	--	------------------------	---

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? ✓

Number of child of this mother, including present birth... 2... Number of child of this mother now living, including present birth... 1...

FATHER  
FULL NAME Mr Joseph Lavery  
RESIDENCE Coeur d'Alene  
COLOR white AGE AT LAST BIRTHDAY 31 (Years)  
BIRTHPLACE Canada  
OCCUPATION Mill worker

MOTHER  
FULL MAIDEN NAME Laura Emily Secaur  
RESIDENCE Coeur d'Alene  
COLOR White AGE AT LAST BIRTHDAY 27 (Years)  
BIRTHPLACE Wisconsin  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was born alive or stillborn at 6 A M. on the date Aug 1 stated.

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W H Kaedgen

Give names added from a supplemental report.

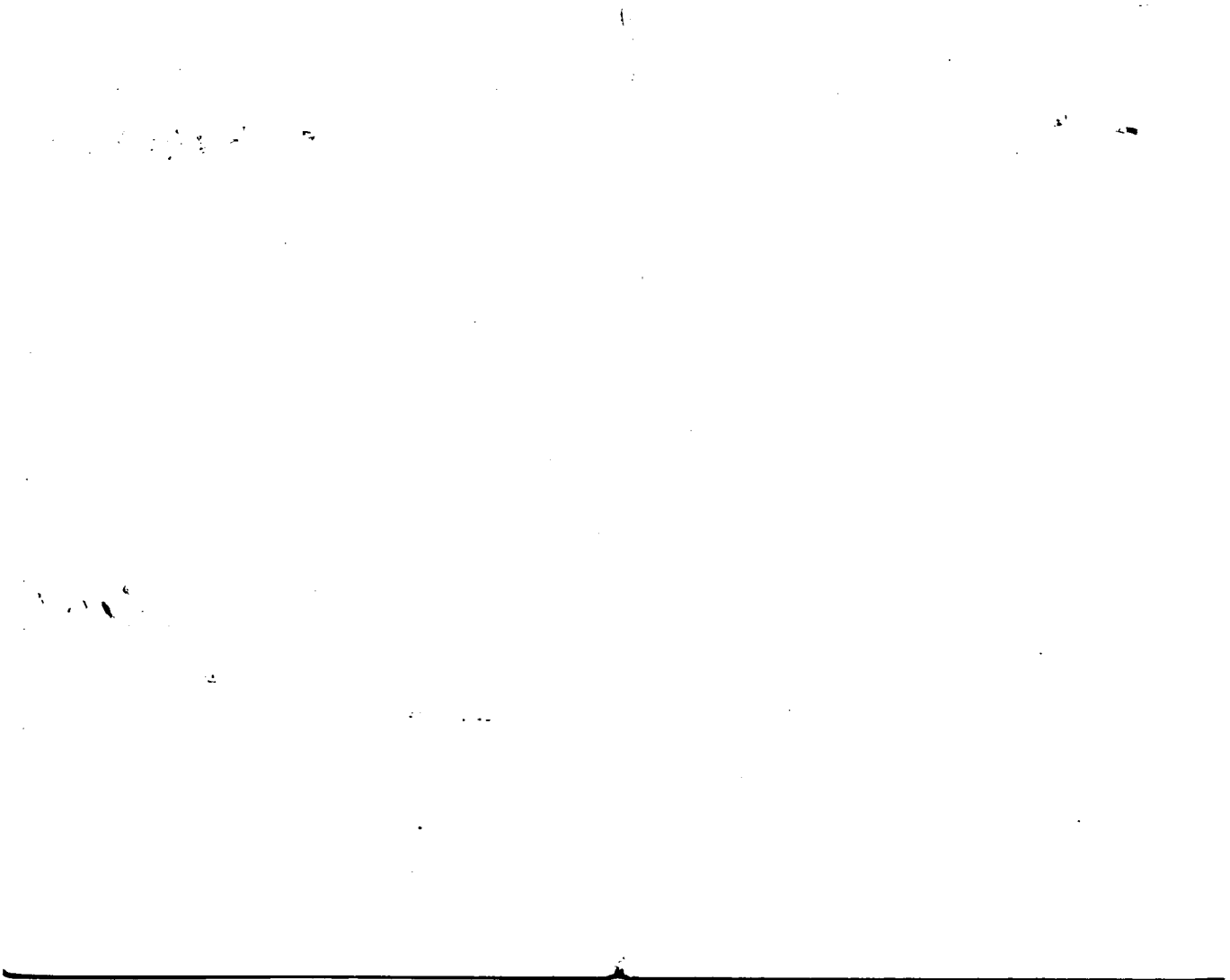
Physician  
(Physician or midwife)  
Caesar H Line, Ida.

....., 19.....

Address Caesar H Line, Ida.  
Filed Aug 2 1922 D D Drunson

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Boise* Registration District No. *30*  
City of *Boise* (No. *1157* St.)

File No. *39373*  
Registered No. *1107*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Infant Garvey*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

## 6. DATE OF BIRTH

*Aug 1 1922*  
(Month) (Day) (Year)

## 7. AGE

— Yrs. — Mos. — ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) *Idaho*

## 10. NAME OF FATHER

*William Garvey*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Canada*

## 12. MAIDEN NAME OF MOTHER

*Laura Lepore*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Ohio*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William Garvey*

(Address) *Boise & Main St*

## 15.

Filed *9/1*

19 *22*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Aug 1 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...  
that I last saw h. *alive* on 19...  
and that death occurred on the date stated above, at *9:30* A.M.

The CAUSE OF DEATH\* was as follows:

*still born; heart tied in cord. shutting off circulation*

(Duration) *1* yrs. *1* mos. *1* ds.

Contributory  
(Secondary)

(Duration) *1* yrs. *1* mos. *1* ds.

(Signed) *J. K. Horder*

19 *22*

(Address) *Boise*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. ... mos. ... days. In the State... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Thomas Cemetery* *Aug 1 1922*

## 20. UNDERTAKER

ADDRESS

*Boise* *Boise*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery, and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

613-000 108-113  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Kootenai  
City of Coeur d'Alene  
No. 30 St. REPUBLIC District No. 1051 File No. 106693  
Hospital \_\_\_\_\_ Primary Registration District No. 1454 Registered No. 11-0-2

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	Date of birth	192
	(To be answered only in event of plural births)				(Month) (Day) (Year)	

What bactericidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth... 2 ... Number of children of this mother now living, including present birth... 1 ...

FATHER  
FULL NAME John Robert Waligurs  
RESIDENCE Coeur d'Alene, Ida  
COLOR white AGE AT LAST BIRTHDAY 35  
(Years)  
BIRTHPLACE Mich  
OCCUPATION machinist

MOTHER  
FULL MAIDEN NAME Anna Jacobs  
RESIDENCE Coeur d'Alene, Ida  
COLOR white AGE AT LAST BIRTHDAY 32  
(Years)  
BIRTHPLACE N. Y.  
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. C. Sawyer

(Physician or midwife)

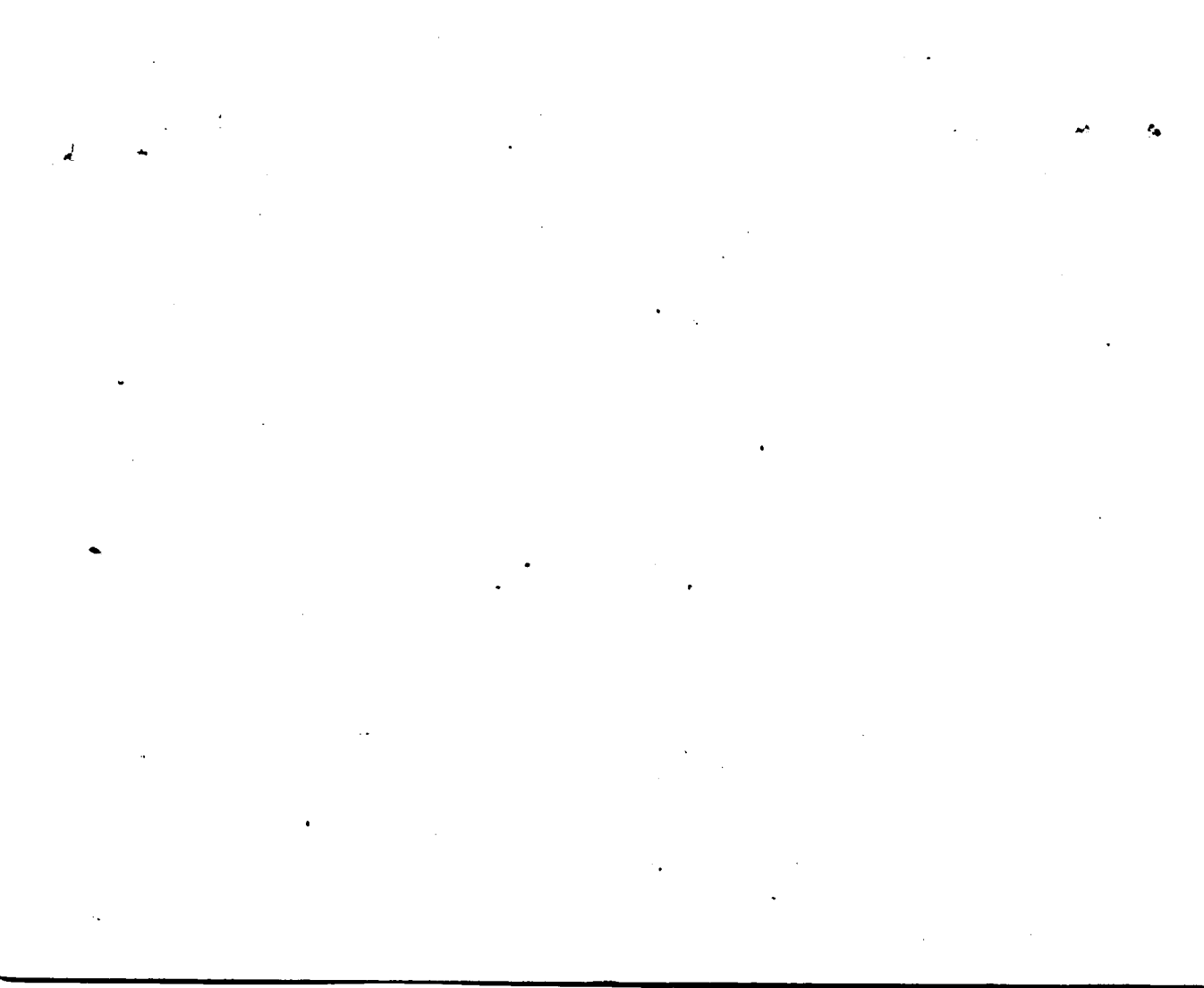
Give names added from a supplemental report.

Address Coeur d'Alene, Ida

Filed Dec 5 1922

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No. 918 West Garden St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

## 6. DATE OF BIRTH

## 7. AGE

IF LESS than 1 day  
how many — hrs.  
or — min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed Dec 3 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Death in thro. 4 days before delivery

Lactation

8 mo. gestation

(Duration) Yrs. mos. ds.

Contributory

(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. O. Quinn M. D.

Nov 13 1922 (Address) Cour d'Alene, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state

(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1922

## 20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

466-207,028-759  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Kootenai  
City of Coeur d'Alene  
No. 205 2nd St. Registration District No. 30 File No. 106699  
Hospital Reed Primary Registration District No. 1057 Registered No. 1448  
FULL NAME OF CHILD Betty Louise Moon  
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>    </u> { and { Number in order of birth <u>    </u>	Legitimate? <u>yes</u>	Date of birth <u>Nov. 7</u> 192 <u>2</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

FATHER  
FULL NAME Clark Blakeley Moon  
RESIDENCE Pocatello, Ida.  
COLOR white AGE AT LAST BIRTHDAY 33 (Years)  
BIRTHPLACE Eagle River, Wis.  
OCCUPATION Public Accountant

MOTHER  
FULL MAIDEN NAME Ruth Eleanor Herbert  
RESIDENCE Pocatello, Ida.  
COLOR white AGE AT LAST BIRTHDAY 30 (Years)  
BIRTHPLACE Julesburg, Colorado  
OCCUPATION Junior Accountant

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at      M.  
on the date above stated. (Born alive or stillborn)

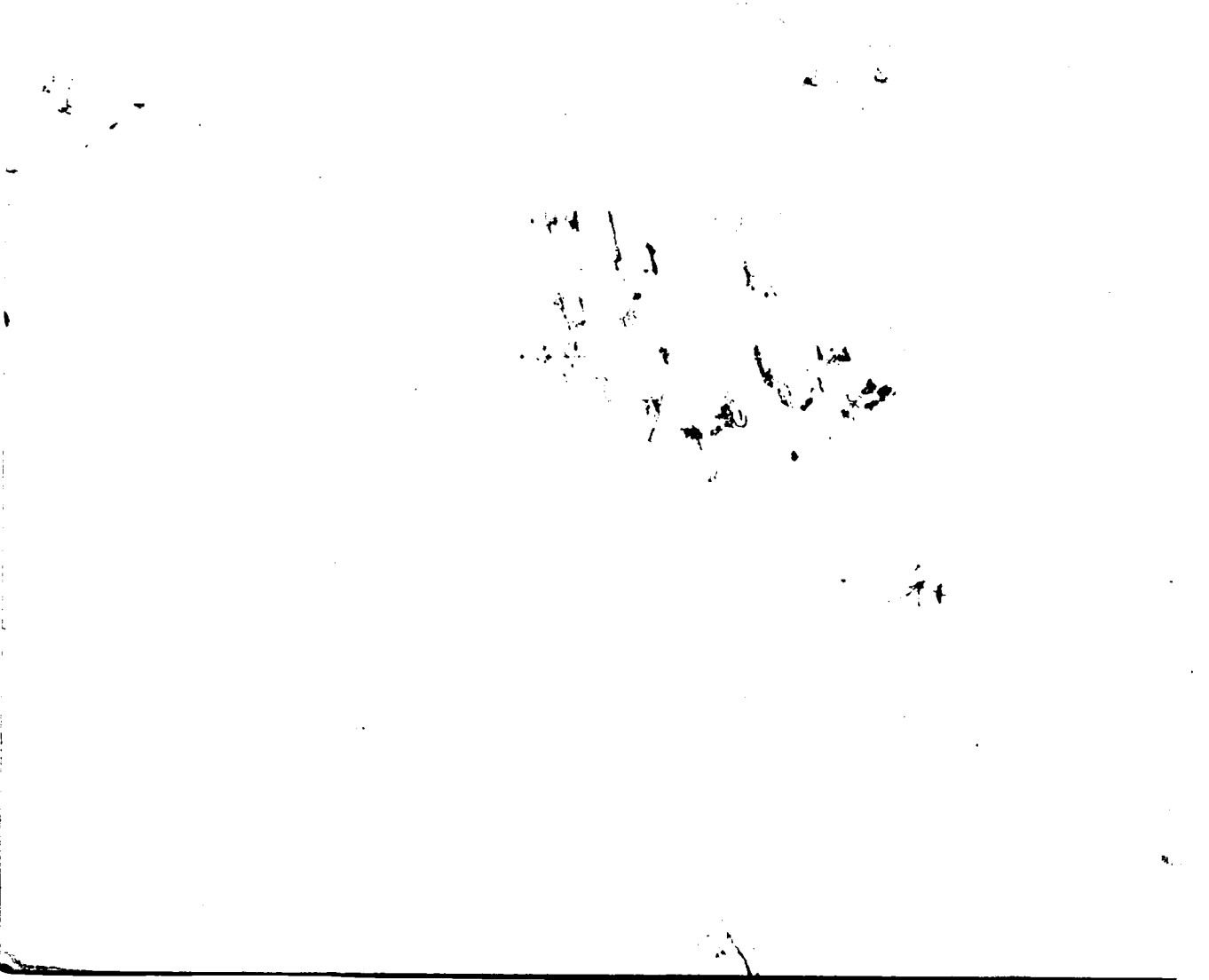
\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. C. Sawyer Dr.  
Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address Coeur d'Alene, Ida.

Filed Dec 4 1922 J. C. Sawyer  
Registrar.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH  
 County of *Porter* Registration District No. *30*  
 City of *Camden* Primary Registration District No. *1051*  
 (No. *Reed* *Moore* St.)

File No. *40036*  
 Registered No. *1138*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Infant Moore*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED *single*  
 (Write the word.)

## 6. DATE OF BIRTH

*Nov 7 1922*  
 (Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
 how many — hrs.  
 or — min.?

— Yrs. — Mos. — ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) *Idaho*

## 10. NAME OF FATHER

*Clark B Moore*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Id*

## 12. MAIDEN NAME OF MOTHER

*Ruth E Garhart*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Id*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *C B Moore*

(Address) *Camden Idaho*

## 15.

Filed *Dec 3 1922* *D. D. Brennan*  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Nov 7 1922*  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Still born*

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address) *Camden Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Forest Cemetery*

## DATE OF BURIAL

*11/8 1922*

## 20. UNDERTAKER

*C B Moore*

## ADDRESS

*Camden Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



268-1021029-766

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of Latah.

NOV 16 1922

CERTIFICATE OF BIRTH

S  
106728City of Potlatch, Id.Registration District No. 65File No. 106728

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2145

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Junior. Boyer.Sex of  
ChildMaleTwin  
Triplet  
or other?☒

and

Number  
in order  
of birth☒

(To be answered only in event of plural births)

Legiti  
mate?YesDate of  
BirthNov21922

(Month)

(Day)

(Year)

FULL  
NAMEOletis Boyer.

FATHER

FULL  
MAIDEN  
NAMELuella Poore.

MOTHER

RESIDENCE

Potlatch - Id.

RESIDENCE

Potlatch Id.

COLOR

WhiteAGE AT LAST  
BIRTHDAY21

(Years)

COLOR

WhiteAGE AT LAST  
BIRTHDAY20

(Years)

BIRTHPLACE

Indiana.

BIRTHPLACE

Wash.

OCCUPATION

Laborer

OCCUPATION

Housewife.Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.Still Born.  
(Born alive or stillborn)at 8 P M.\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Dr. E. Thompson.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

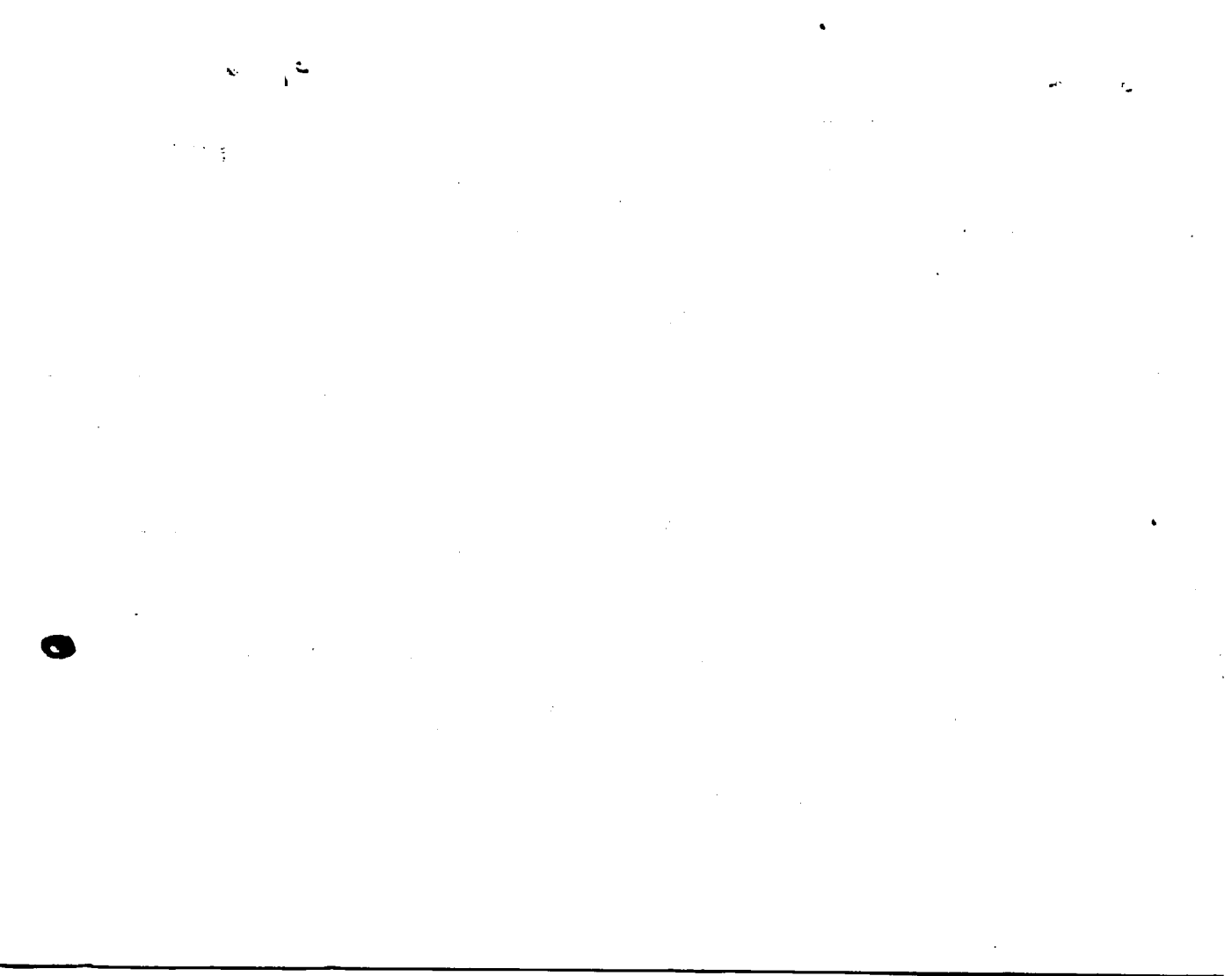
P. O. Box 10

Filed

Nov. 3019 22Dr. E. Thompson

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH. **RECEIVED**  
Registration District No. 65  
County of Idaho **NOV 13 1922**  
City of Booth **BUREAU OF**  
Primary Registration District No. 2145  
St. Idaho **STATISTICS**

File No. 40062  
Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Junior Boyer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single  
(Write the word.)

6. DATE OF BIRTH. Nov 2 1922  
(Month) (Day) (Year)

7. AGE \_\_\_\_\_ IF LESS than 1 day  
Yrs. ✓ Mos. ✓ ds. ✓ how many ✓ hrs. or min. ✓

8. OCCUPATION  
(a) Trade, profession or particular kind of work. none  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9. BIRTHPLACE  
(State or Country) Idaho

10. NAME OF FATHER Cletis Boyer

11. BIRTHPLACE OF FATHER  
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER Luella Poore

13. BIRTHPLACE OF MOTHER  
(State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Cletis Boyer  
(Address) Booth

15. Filed Nov 3<sup>rd</sup> 1922 D. J. Thompson  
Local Registrar

16. DATE OF DEATH Nov 2 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191 \_\_\_\_\_ to ✓ 191 \_\_\_\_\_  
that I last saw him ✓ alive on ✓ 191 \_\_\_\_\_  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:  
Still Born  
(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_  
(Signed) J. Thompson M. D.  
11/3/1922 (Address) Booth

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL Idaho Wash. DATE OF BURIAL Nov 5 1922

20. UNDERTAKER Parents ADDRESS Booth

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

159-209-030-243

PLACE OF BIRTH

STATE OF IDAHO

Form V. S. No. 11-C-23m-3-37

BUREAU OF VITAL STATISTICS

County of *Lincoln*

NOV 18 1922

CERTIFICATE OF BIRTH

City of *North Fork*BUREAU OF VITAL  
STATISTICSFile No. *S* 106763...

No. .... St.

Primary Registration District No. *2.116*

Registered No. ....

Hospital .....

FULL NAME OF CHILD .....

Sex of Child <i>Female</i>	Twin Triplet or other? <i>No</i>	and { Number in order of birth	Legitimate? <i>Yes</i>	Date of Birth <i>Oct-9th</i>
(To be answered only in event of plural births)				(Month) (Day) (Year)
FATHER FULL NAME <i>Thos A Ferrell</i>			MOTHER FULL MAIDEN NAME <i>Louisa Buckner</i>	
RESIDENCE <i>North Fork</i>			RESIDENCE <i>North Fork</i>	
COLOR <i>wh</i>	AGE AT LAST BIRTHDAY <i>38</i>		COLOR <i>wh</i> AGE AT LAST BIRTHDAY <i>38</i>	
(Years)			(Years)	
BIRTHPLACE <i>Id</i>			BIRTHPLACE <i>Id</i>	
OCCUPATION <i>Farmer</i>			OCCUPATION <i>House</i>	

Number of child of this mother, including present birth ..... Number of children of this mother now living, including present birth .....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *born dead* (born alive or stillborn) at *4 P* M. on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *Dr. Wm. H. Smith*

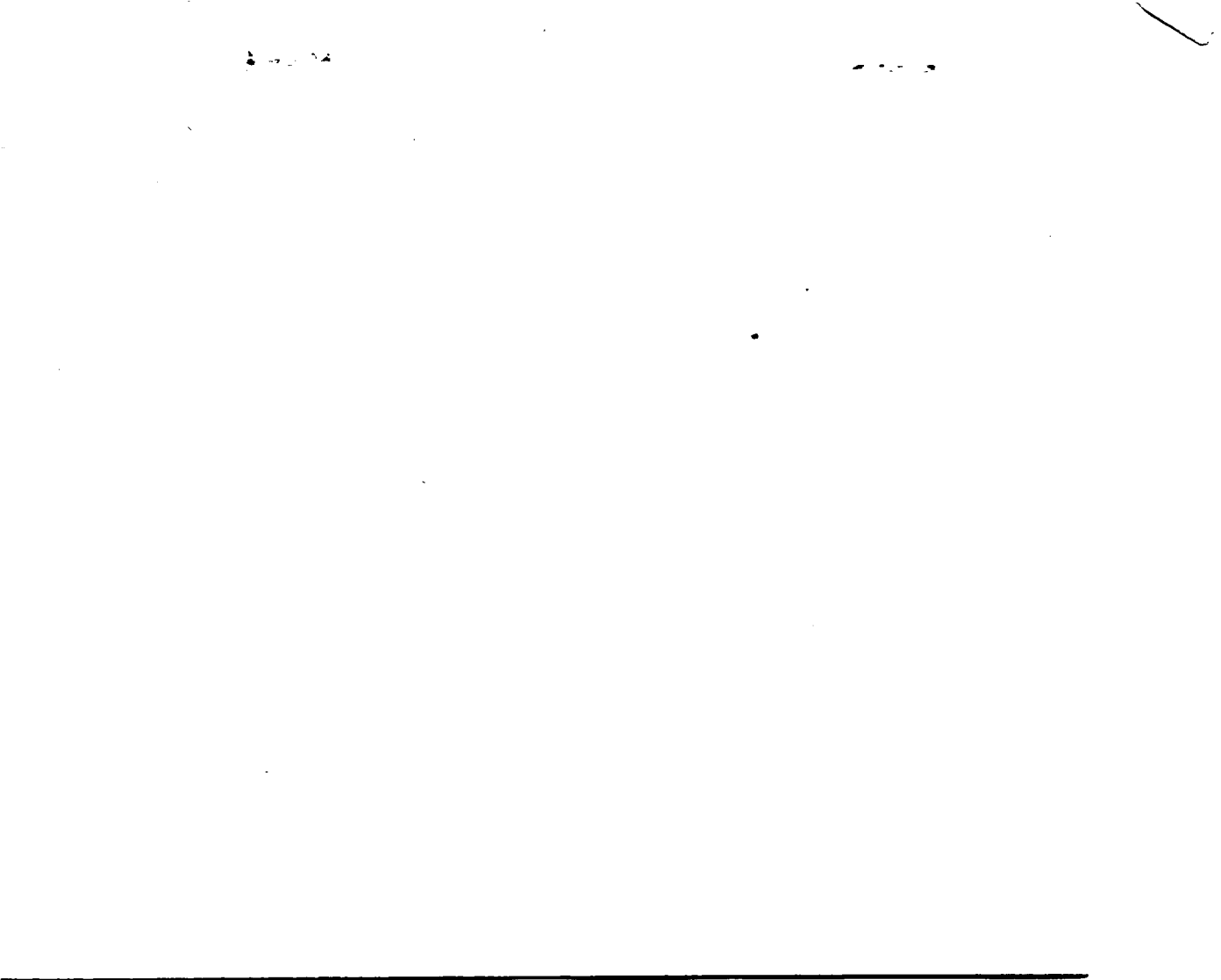
(Physician or midwife)

Given names added from a supplemental report.

Address *Salmon*Filed *Nov 11* 1922

Registrar

*Elis Bellamy*  
*dep*  
 Registrar



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

251-2041033 -893

PLACE OF BIRTH

RECEIVED

Form V. S. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

County of Madison DEC 6 1922

CERTIFICATE OF BIRTH

City of Burton

Registration District No. 100

File No. 106807

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital Res

Primary Registration District No. 2178

Registered No. 282

FULL NAME OF CHILD

Hazel Beardall

Sex of Child

female

Twin  
Triplet  
or other?

and  
Number  
in order  
of birth

Legiti  
mate?

yes

Date of  
Birth

Nov 4

1922

(To be answered only in event of plural births)

(Month) (Day) (Year)

FULL  
NAME

FATHER

John R Beardall

FULL  
MAIDEN  
NAME

MOTHER

Hazel Hill

RESIDENCE

Burton

RESIDENCE

Burton

COLOR

White

AGE AT LAST  
BIRTHDAY

32

(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

28

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Ky

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

Stillborn at 4:10 A.M.  
(Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Mary A Watts

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Rehburg Idaho

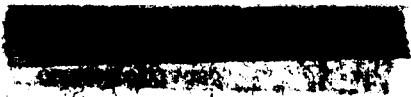
Filed

11/29

1922

J. C. Young  
Registrar

Registrar





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

## CERTIFICATE OF DEATH.

 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

 1. PLACE OF DEATH, **RECEIVED**  
 County of *Madison* JAN 3 1922  
 City of *Boyle* **VITAL**  
 Registration District No. *100*  
 Primary Registration District No. *2178*  
 (No. ) (St.)

 File No. **40617**  
 Registered No. *71*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Baley Beardsall*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

 3. SEX *Male* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED. *Single*  
 (Write the word.)

 6. DATE OF BIRTH *Nov 4 1922*  
 (Month) (Day) (Year)

 7. AGE *1* IF LESS than 1 day  
 how many yrs. mos. ds. hrs. or min.

## 8. OCCUPATION

 (a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business, or establishment in which employed (for employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

*11/4**1922*
*J. R. Beardsall*  
 Local Registrar

 16. DATE OF DEATH *Nov 4 1922*  
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from *191* to *191*,  
 that I last saw him alive on *191*,  
 and that death occurred on the date stated above, at *M.*  
 The CAUSE OF DEATH\* was as follows:
*Still Born*

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. R. Beardsall* M. D.19 (Address) *Boyle*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Burton**11/4 1922*

## 20. UNDERTAKER

## ADDRESS

*J. R. Beardsall**Boyle*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

165-119-035-813  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

106897

County of Myer

City of Leiston

No. 1514 Main St.

Hospital White

Registration District No. 96

File No. 106897

Primary Registration District No. 1009

Registered No. 240

FULL NAME OF CHILD

No name

(Certificate of no value without full name of child.)

Sex of Child male

Twin  
Triplet  
or other?

and  
Number  
in order  
of birth

Legiti-  
mate? yes

Date of birth Nov 19 1922  
(Month) (Day) (Year)

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER  
FULL NAME Evan Elsworth Jones

RESIDENCE Asotin Wash

COLOR white AGE AT LAST BIRTHDAY 21 (Years)

BIRTHPLACE Walla-Walla Wash

OCCUPATION Inforen

MOTHER  
FULL MAIDEN NAME Gincy May Halsey

RESIDENCE Asotin Wash

COLOR white AGE AT LAST BIRTHDAY 23 (Years)

BIRTHPLACE mouth of Wilson Va

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 11 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. D. Clark  
physician  
(Physician or midwife)

Give names added from a supplemental report.

12/7/ 1922

F. T. Harris, M.D.  
Registrar.

Address Leiston, Idaho  
Filed Dec 7 1922 F. T. Harris  
Registrar.

11.11.11

## CERTIFICATE OF DEATH

1. PLACE OF DEATH *Leiviston, Idaho* DEC 11 1922  
 Registration District No. 96  
 County of *Boonville* Primary Registration District No. 1009  
 City of *Leiviston* (No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME \_\_\_\_\_

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 40109  
 Registered No. 208

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
 (Write the word.)

6. DATE OF BIRTH *Nov 27 1922*  
 (Month) (Day) (Year)

7. AGE *Still Born* IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Leiviston Ida.*  
 (State or Country)

10. NAME OF FATHER *E E Jones*

11. BIRTHPLACE OF FATHER *Boonville County Wash*  
 (State or Country)

12. MAIDEN NAME OF MOTHER *Quincy Mae Halsay*

13. BIRTHPLACE OF MOTHER *Virginia*  
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs John Jones*  
 (Address) *Clarkston Wash*

15. Filed *12/7/ 1922* F. T. Harris, M.D.  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH *1846*

16. DATE OF DEATH *Dec 27 1922*  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Nov 27 1922* to *Nov 27 1922*  
 that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date stated above, at \_\_\_\_\_ M.  
 The CAUSE OF DEATH\* was as follows:

*Still born  
 Placenta praevia.*

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
 (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *W D Clagh* M. D.

(Address) *Leiviston Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL *Clarkston Wash* DATE OF BURIAL *Nov 27 1922*

20. UNDERTAKER *H R Merchant* ADDRESS *Clarkston Wash*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated

659-1291040-791

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

Bureau of Vital Statistics

County of Shoshone

NOV 27 1922

CERTIFICATE OF BIRTH

City of Wallace

BUREAU OF VITAL STATISTICS

Registration District No. 70

File No.

106981

No. Cedar St.

Primary Registration District No. 1011

Registered No. 106

Hospital Wallace

FULL NAME OF CHILD John Severino Ferrat

Sex of Child <u>male</u>	Twin, Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>8</u> (Month) <u>11</u> (Day) <u>1922</u> (Year)
FATHER			MOTHER	
FULL NAME <u>Alexander Ferrat</u>			FULL MAIDEN NAME <u>Lena Giacchino</u>	
RESIDENCE <u>milan</u>			RESIDENCE <u>milan</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	
BIRTHPLACE <u>Italy</u>		BIRTHPLACE <u>Wyoming</u>		
OCCUPATION <u>miner</u>		OCCUPATION <u>Housewife</u>		

Number of child of this mother, including present birth. 2

Number of children, of this mother, now living, including present birth. 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive or stillborn on the date above stated.

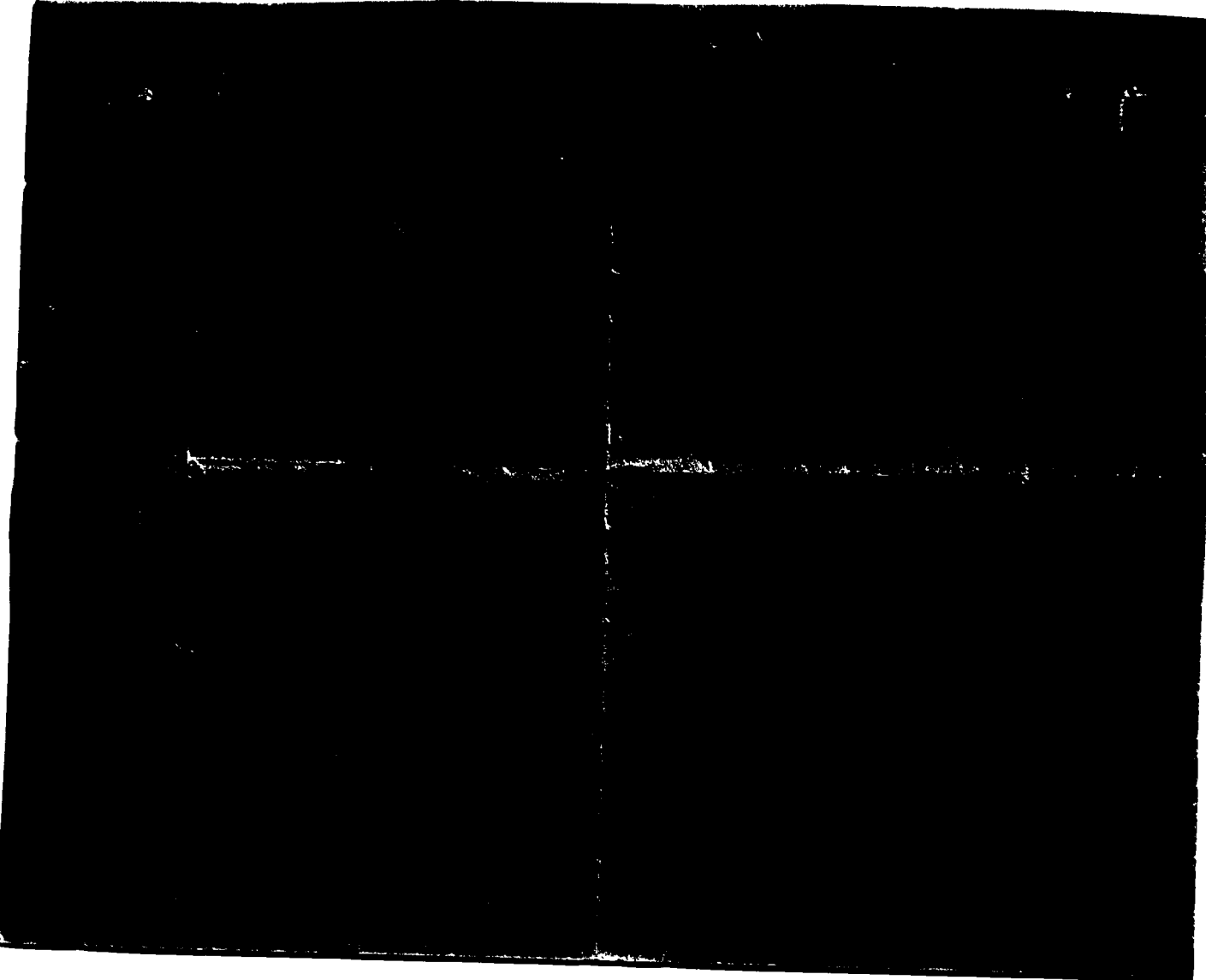
\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Phil Rom at 11:30 A.M.  
 (Physician or Midwife)

Given names added from a supplemental report

19

Address Sept 10 1922 F L Under  
 Registrar





FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH *Shoshone* District No. *70* State of Idaho  
 County of *Wallace* Registration District No. *101* BOARD OF HEALTH  
 City of *Wallace* (No. *Wallace Hospital*) Bureau of Vital Statistics  
 File No. *40170*  
 Registered No. *86*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Infant of Alex Ferret*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED  
 (Write the word.)

6. DATE OF BIRTH *Aug 29 1922*  
 (Month) (Day) (Year)

7. AGE *still born* IF LESS than 1 day  
 Yrs. Mos. da. how many hrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Idaho*  
 (State or Country)

10. NAME OF FATHER *Alex Ferret*

11. BIRTHPLACE OF FATHER *Italy*  
 (State or Country)

12. MAIDEN NAME OF MOTHER *Lena Frachino*

13. BIRTHPLACE OF MOTHER *Wyoming*  
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) *Alex Ferret*  
 (Address) *Mullan Ida*

15. *May 30 1922 F. L. Jones*  
 Filed Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Stillborn*  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
 19 to 19  
 that I last saw him alive on 19  
 and that death occurred on the date stated above, at M.  
 The CAUSE OF DEATH\* was as follows:

*Stillborn*  
 (Duration) Yrs. mos. ds.  
 Contributory (Secondary)  
 (Duration) Yrs. mos. ds.  
 (Signed) *Frank L. Jones* M. D.  
 1922 (Address) *Wallace Idaho*

\*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days  
 Where was disease contracted if not at place of death?  
 Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Wallace Idaho* DATE OF BURIAL *Aug 30 1922*  
 UNDERTAKER *W. J. Worstell* ADDRESS *Wallace*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

263-108-042-219  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 107025  
35.

County of Twin Falls

City of Twin Falls

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Hospital County

Primary Registration District No. 1085.

Registered No. \_\_\_\_\_

FULL NAME OF CHILD W. name (infant) Bolger Still Born

(Certificate of no value without name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>—</u> and { <u>—</u> } Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of birth <u>10/5</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? Yes Argemol 10%

Number of child of this mother, including present birth One Number of child of this mother now living, including present birth One

FULL NAME Howard Bolger FATHER

FULL MAIDEN NAME Wolch Barner MOTHER

RESIDENCE 636 - 3d Ave W. Twin Falls

RESIDENCE 636 - 3d Ave Washington

COLOR White AGE AT LAST BIRTHDAY 21 (Years)

COLOR White AGE AT LAST BIRTHDAY 18 (Years)

BIRTHPLACE Lincoln Kansas

BIRTHPLACE Washington (State)

OCCUPATION Meat cutter

OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still Born at 7:00 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. W. Emery

(Physician or midwife)

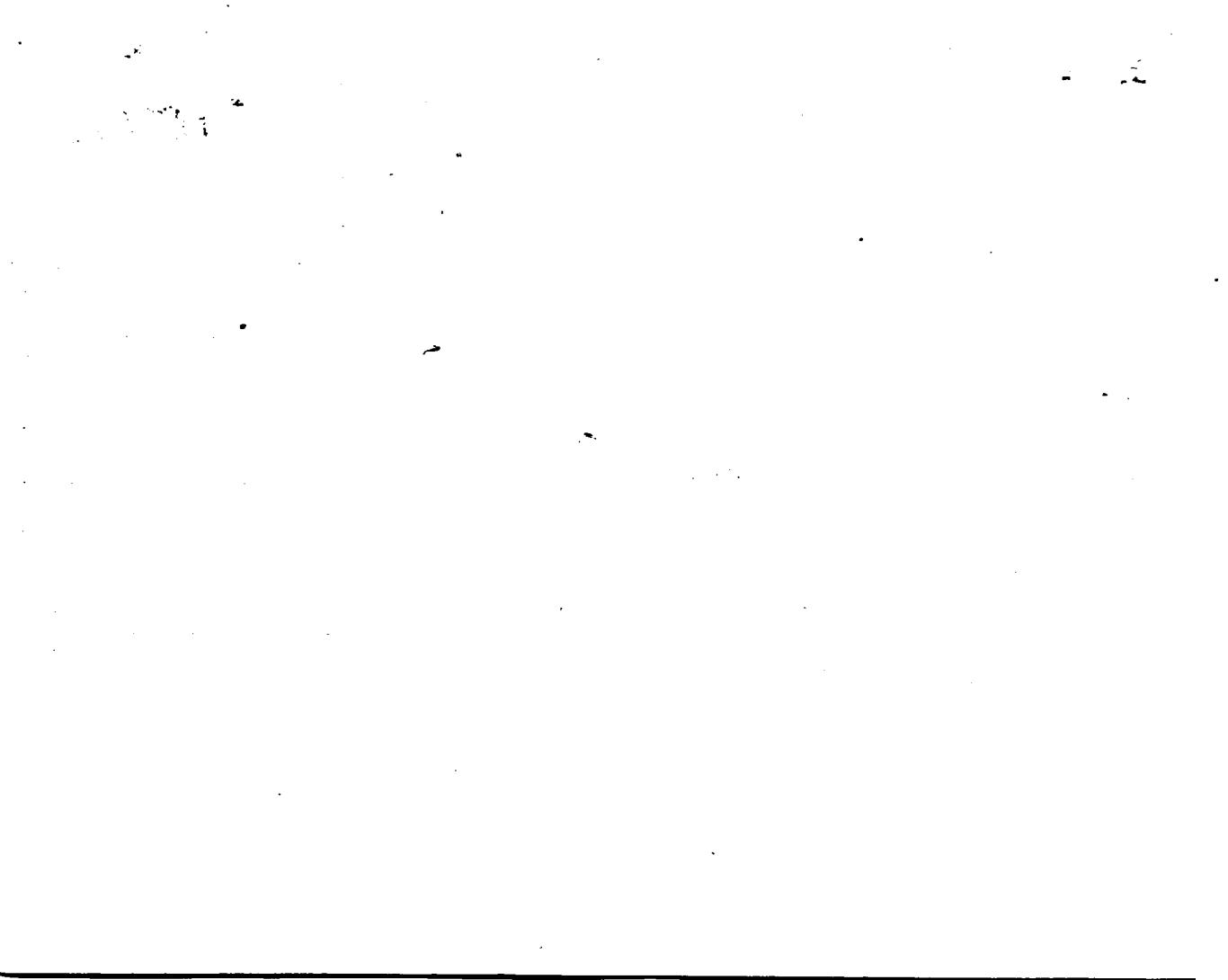
Give names added from a supplemental report.

Address 235 - 5th Ave E. Twin Falls

Filed Nov. 1 1922 John H. Doughlin

Registrar.

Registrar.



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Trinity Falls Registration District No. 1085  
 City of Trinity Falls Registration District No. 1085 St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

No name (infant) Bolz

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 40196

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED Infant  
 (Write the word.)

## 6. DATE OF BIRTH

Oct 8 1922  
 (Month) (Day) (Year)

## 7. AGE

Still born Mos. \_\_\_\_\_ ds. \_\_\_\_\_  
 IF LESS than 1 day how many hrs. \_\_\_\_\_ min. ?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

Infant

## 9. BIRTHPLACE

(State or Country)

Co Hospital

## 10. NAME OF FATHER

Howard Bolz

## 11. BIRTHPLACE OF FATHER

(State or Country)

Lincoln Kansas

## 12. MAIDEN NAME OF MOTHER

Violet Barnes

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Washington (State)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Howard Bolz

(Address)

666 - 3rd Ave. Wash.

## 15.

Filed November 1 -- 1922

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Oct 8 1922  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY That I attended deceased from

that I last saw him Stillborn 19\_\_\_\_  
 and that death occurred on the date stated above, at \_\_\_\_\_ M.  
 The CAUSE OF DEATH\* was as follows:  
Unknown

(Duration) Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory (Secondary)

(Duration) Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) W. E. Jones M. D.

1922 (Address) Trinity Falls, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Trinity Falls Oct 9 1922

## 20. UNDERTAKER

## ADDRESS

J. J. Harrison Trinity Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

845-103.042 253  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Town Falls RECEIVED  
City of Town Falls NOV 13 1922  
No. 497-4th DIST. Registration District No. 37. File No. 107034  
Hospital Lin Primary Registration District No. 1085. Registered No. \_\_\_\_\_  
FULL NAME OF CHILD Childstone (Rue)  
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>no</u> and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Oct 3</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? None (still born)

Number of child of this mother, including present birth... 7 Number of child of this mother now living, including present birth... 0

FATHER  
FULL NAME Ralph E. Rue  
RESIDENCE Town Falls Ida.  
COLOR White AGE AT LAST BIRTHDAY 25 (Years)  
BIRTHPLACE Oklahoma  
OCCUPATION Book Keeper

MOTHER  
FULL MAIDEN NAME William L. Bell  
RESIDENCE Town Falls Ida.  
COLOR White AGE AT LAST BIRTHDAY 24 (Years)  
BIRTHPLACE Texas  
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... Childstone at... 3:30 A. M.  
on the date above stated. (Born alive or stillborn) 10/3-22

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Childstone  
R. Rue  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address \_\_\_\_\_  
Filed NOV. --- 192 2  
Registrar.

4837

STATION 076

NO

WIND

11/27

10:27

2



STATE OF IDAHO.  
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 12/18 1922.

Dear Madam:

The name of your baby was not filed in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

\* \* \* \* \*

Place (	City _____	File No. _____
of (	St. _____	Date of Birth _____
Birth (	County _____	Sex of Child <u>Male</u>
(	Father _____	Mother _____

I HEREBY CERTIFY that the child herein has been named:

Was dead when born

Mrs R. G. King

Signature of Father or Mother.

RECEIVED  
1922  
JAN 1

1944

1944

1944

1944

1944

1944

1944

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 37.

County of *Twin Falls*  
City of *Twin Falls*

Registration District No. 1085.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME OF DECEASED

*John F. Loughlin*  
RECEIVED  
NOV 18 1922  
STATE OF IDAHO  
DEPT. OF HEALTH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 40192

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female* *White*

*Single*  
(Write the word.)

6. DATE OF BIRTH

*Oct* *3* *1922*  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many..... hrs.  
or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Twin Falls Idaho*

10. NAME OF FATHER

*Ralph G. Lue*

11. BIRTHPLACE OF FATHER

(State or Country) *Okla., Norman*

12. MAIDEN NAME OF MOTHER

*Lillian Bell*

13. BIRTHPLACE OF MOTHER

(State or Country) *Texas*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Ralph G. Lue*  
(Address) *437 4th Ave West*

15.

Filed *Nov. 1* 1922

*John F. Loughlin*  
Local Registrar

16. DATE OF DEATH

*Oct* *3* *22*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*10/3* 19*22* to *10/3* 19*22*  
that I last saw h. *En* alive on *10/3* 19*22*  
and that death occurred on the date stated above, at *H. A. M.*  
The CAUSE OF DEATH\* was as follows:  
*Strangulation of cord*

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Birth Injuries*

(Duration) Yrs. mos. ds.

(Signed) *C. A. Lue* M. D.

*10/3* 19*22* (Address) *Twin Falls*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Twin Falls* 19*22*

20. UNDERTAKER

ADDRESS

*J. E. De Witt & Co* *Twin Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

369-247-001-853  
PLACE OF BIRTHSTATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Ada JAN 1City of Bone SURE

## CERTIFICATE OF BIRTH

No. South Bone St.Registration District No. 2File No. 107170Hospital Ida.Primary Registration District No. 1004Registered No. 523FULL NAME OF CHILD Evelyn Mae Carn

(Certificate of no value without full name of child.)

Sex of Child GirlTwin  
Triplet  
or other?

{ and }

Number  
in order  
of birthLegiti-  
mate? yesDate of  
birth Dec. 17

(Month)

(Day)

1922  
(Year)What bactericidal solution was used in eyes? NoneNumber of child of this mother, including present birth... 8Number of children of this mother now living, including present birth... 7

FULL NAME FATHER

Willis F. Carn

RESIDENCE

Bone

COLOR

WhiteAGE AT LAST  
BIRTHDAY4/1  
(Years)

BIRTHPLACE

Georgia

OCCUPATION

Laborer

FULL MAIDEN NAME MOTHER

Hazel Helma

RESIDENCE

Bone

COLOR

WhiteAGE AT LAST  
BIRTHDAY34  
(Years)

BIRTHPLACE

Mo.

OCCUPATION

Housewife

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was... Stillborn at... 8-45 P. M.  
on the date above stated. (Born alive or stillborn)\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.(Signature) R. S. Gregory

(Physician or midwife)

Give names added from a supplemental report.

1922

Address 1107 N. 8th St. Bone IdaFiled Dec 19 1922 R. N. Pratt

Registrar.

Registrar.

Y WITH UNFADING INK—THIS IS A PERMANENT RECORD  
and the number of each, in order of birth stated.

DEPARTMENT OF HEALTH AND WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 101150  
Primary Registration District No. 101150  
Registered No. 101150

FULL NAME OF CHILD

(Write name of no value without full name of child)

Sex of Child	Number of Children	Number of Siblings	Number of Siblings
Male	1	1	1
Female	0	0	0

Place of Birth	Place of Birth
City	City
State	State

FATHER	MOTHER
NAME	NAME
DATE OF BIRTH	DATE OF BIRTH
PLACE OF BIRTH	PLACE OF BIRTH

COLOR	COLOR
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY

BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
Signature

(1) Signature of Registrar
(2) Signature of Registrar

Signature of Registrar
Signature of Registrar

Signature of Registrar
Signature of Registrar

Signature of Registrar
Signature of Registrar

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

Registration District No. 2  
County of Ada Primary Registration District No. 1004  
City of Boise (No. 1519 Grant St. St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Evelyn Mae Corn

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 40270Registered No. 299

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

Dec 17 1922  
(Month) (Day) (Year)

## 7. AGE

Stillsborn 1 day  
how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

None

## 9. BIRTHPLACE

(State or Country) Boise, Idaho

## 10. NAME OF FATHER

Willis, Corn

## 11. BIRTHPLACE OF FATHER

(State or Country) Georgia

## 12. MAIDEN NAME OF MOTHER

Hazel Helms

## 13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm M Bratney

(Address) Boise, Idaho

## 15.

Filed 12/18 1922 R H Craft  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec 17 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Dec 17 1922 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH\* was as follows:

Stillsborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. S. Gregory M. D.

12/17/22 (Address) Boise, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

## DATE OF BURIAL

12/18 1922

## 20. UNDERTAKER

Wm M Bratney

## ADDRESS

Boise, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



955-101-001-613  
PLACE OF BIRTH

STATE OF IDAHO  
RECEIVED DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Ada JAN 5 1923  
City of Meridian BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH 107182  
No. \_\_\_\_\_ St. \_\_\_\_\_ Reg. No. \_\_\_\_\_ File No. 61  
Hospital \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Roy James Renner

(Certificate of no value without full name of child.)

Sex of Child Male Twin Twin and Number in order of birth 2 Legitimate? Yes Date of birth Dec 1 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericide solution was used in eyes? NoneNumber of child of his mother, including present birth 3 Number of children of this mother now living, including present birth 8

FATHER  
FULL NAME John Andrew Renner  
RESIDENCE Meridian Ada  
COLOR White AGE AT LAST BIRTHDAY 46 (Years)  
BIRTHPLACE Mayville Mo  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Jessie Virginia Fallon  
RESIDENCE Meridian Ada  
COLOR White AGE AT LAST BIRTHDAY 39 (Years)  
BIRTHPLACE Lonetree Wyo.  
OCCUPATION House wife

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born at 6:20 A. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. R. Summers Jr.  
Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address

Meridian Ada

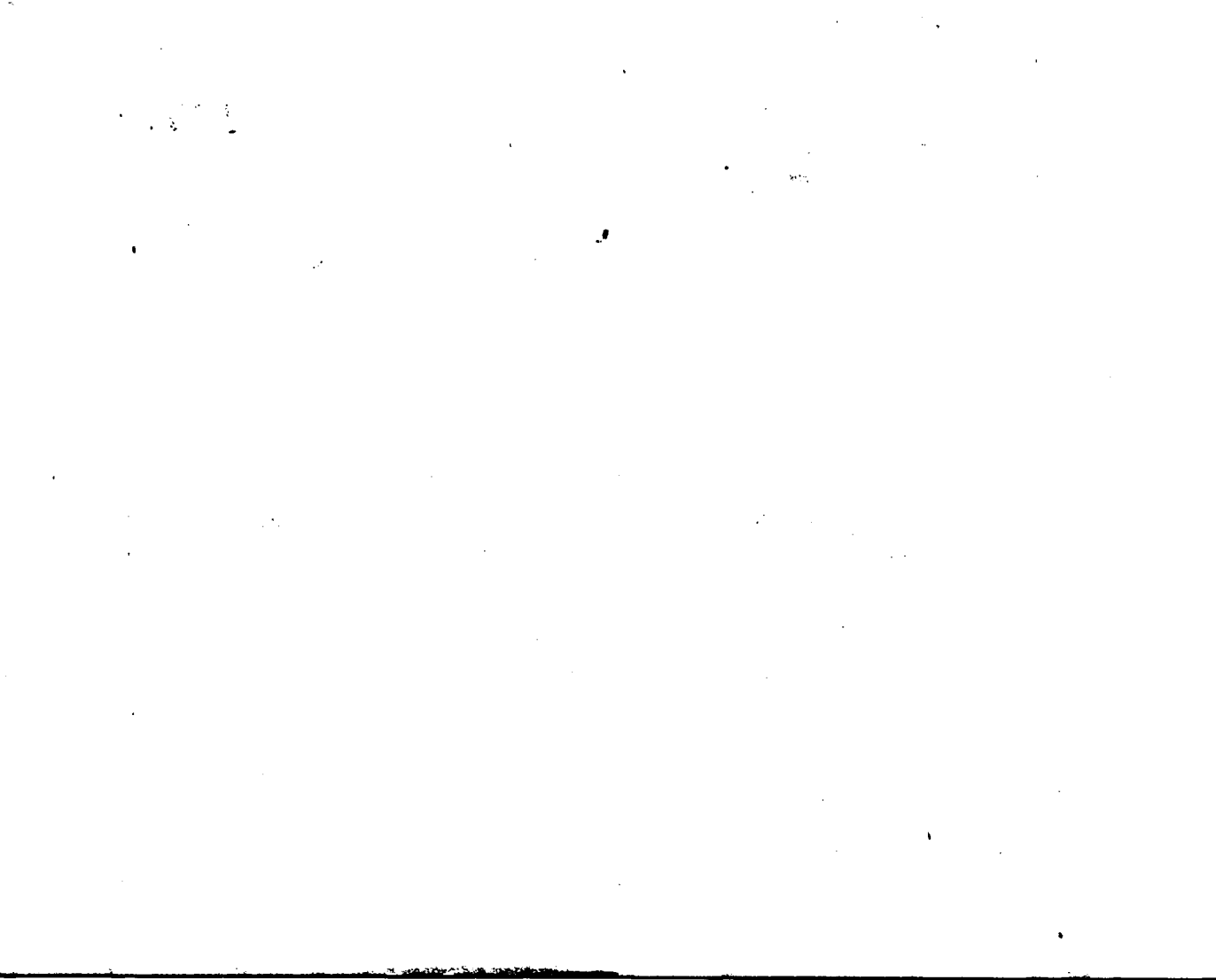
Filed

17/2 1922 J. H. Neal

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

787-219-003-714  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Damascus DEC 30 1922  
City of Pocatello BUREAU OF VITAL STATISTICS  
No. 4th Ave. St. Registrar No. 28 File No. 107225  
Hospital St Anthony's Primary Registration District No. 2141 Registered No. 4657  
FULL NAME OF CHILD Viola Jane Pyper

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>1</u> and <u>1</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>Oct 19</u> 192 <u>2</u> (Month) (Day) (Year)
----------------------------	--	-----------------------------------	------------------------	--

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FULL NAME <u>Alexander Leo Pyper</u>	FATHER	FULL MAIDEN NAME <u>Cal Rose Paul</u>	MOTHER
RESIDENCE <u>556 7th 13th St.</u>		RESIDENCE <u>556 7th 13th St.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Fairview Utah</u>		BIRTHPLACE <u>Seaside Oregon</u>	
OCCUPATION <u>Tailor Maker helper</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

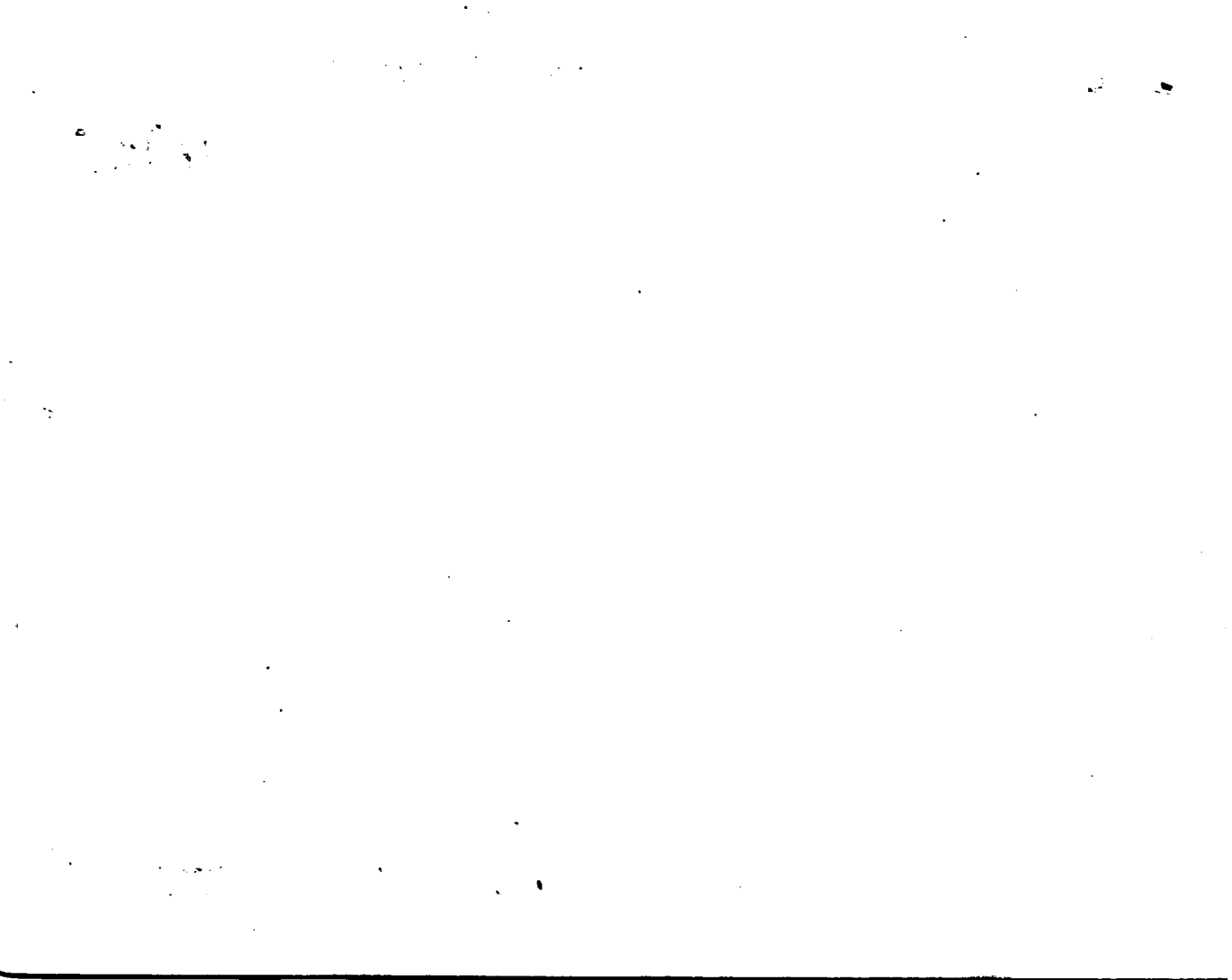
I hereby certify that I attended the birth of this child, who was Stillborn at 10:30 P. M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr A.M. Newton  
(Physician or midwife)

Give names added from a supplemental report.  
....., 19.....  
Registrar.

Address Pocatello Id  
Filed 12/1 1922 Registrar J. J. Garing



FORM V. S. No. 5-A—25 M. 1-19.

## 1. PLACE OF DEATH

County of Bannock Registration District No. 18  
 City of Poratell Primary District No. 2161  
St. Anthony Hospital

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Pyper

## CERTIFICATE OF DEATH

39776  
28

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 53Registered No. 3945

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female White

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant  
(Write the word.)

## 6. DATE OF BIRTH

October 19 1922  
(Month) (Day) (Year)

## 7. AGE

Stillborn  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

## 9. BIRTHPLACE

(State or Country) Poratell Ida.

## 10. NAME OF FATHER

A. L. Pyper

## 11. BIRTHPLACE OF FATHER

(State or Country) Utah.

## 12. MAIDEN NAME OF MOTHER

Eola Paul

## 13. BIRTHPLACE OF MOTHER

(State or Country) Oregon

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

## (Informant)

A. L. Pyper

## (Address)

Poratell

## 15.

## Filed

10/21 1922

J. H. Pyper  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Oct 19 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Oct 19 1922 to Oct 19 1922  
that I last saw him alive on Oct 19 1922  
and that death occurred on the date stated above, at 8 M.  
The CAUSE OF DEATH was as follows:

Stillbirth

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Newton M. D.

Oct 19 22 (Address) Poratell, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Mountain View Home

## DATE OF BURIAL

Oct 24 1922

## 20. UNDERTAKER

Shumacher & Hall

## ADDRESS

Poratell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

249-112-007-236  
PLACE OF BIRTH.

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

107248  
S 83

County of Bannock  
City of Pocatello  
No. 7th ave St. Registration District No. 28 File No. 28  
Hospital St. Anthony's Primary Registration District No. 2161 Registered No. 4674  
FULL NAME OF CHILD Hellen Burnham  
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twins Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Nov-12</u> 192 <u>2</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? .....

Number of child of this mother, including present birth... 6 ... Number of child of this mother now living, including present birth... 5 ...

FATHER		MOTHER	
FULL NAME	<u>Sutthor Charles Burnham</u>	FULL MAIDEN NAME	<u>Minnie Stout</u>
RESIDENCE	<u>142. no-8th. East</u>	RESIDENCE	<u>142. no-8th. East</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>38</u> (Years)	AGE AT LAST BIRTHDAY	<u>38</u> (Years)
BIRTHPLACE	<u>Richmond Utah</u>	BIRTHPLACE	<u>White Cloud- Kansas</u>
OCCUPATION	<u>Barber</u>	OCCUPATION	<u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... Still born ... at... 4:45 ... a. M.  
on the date above stated. (Born alive or stillborn)

{ \*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth. }

(Signature) Dr. A. M. Newton

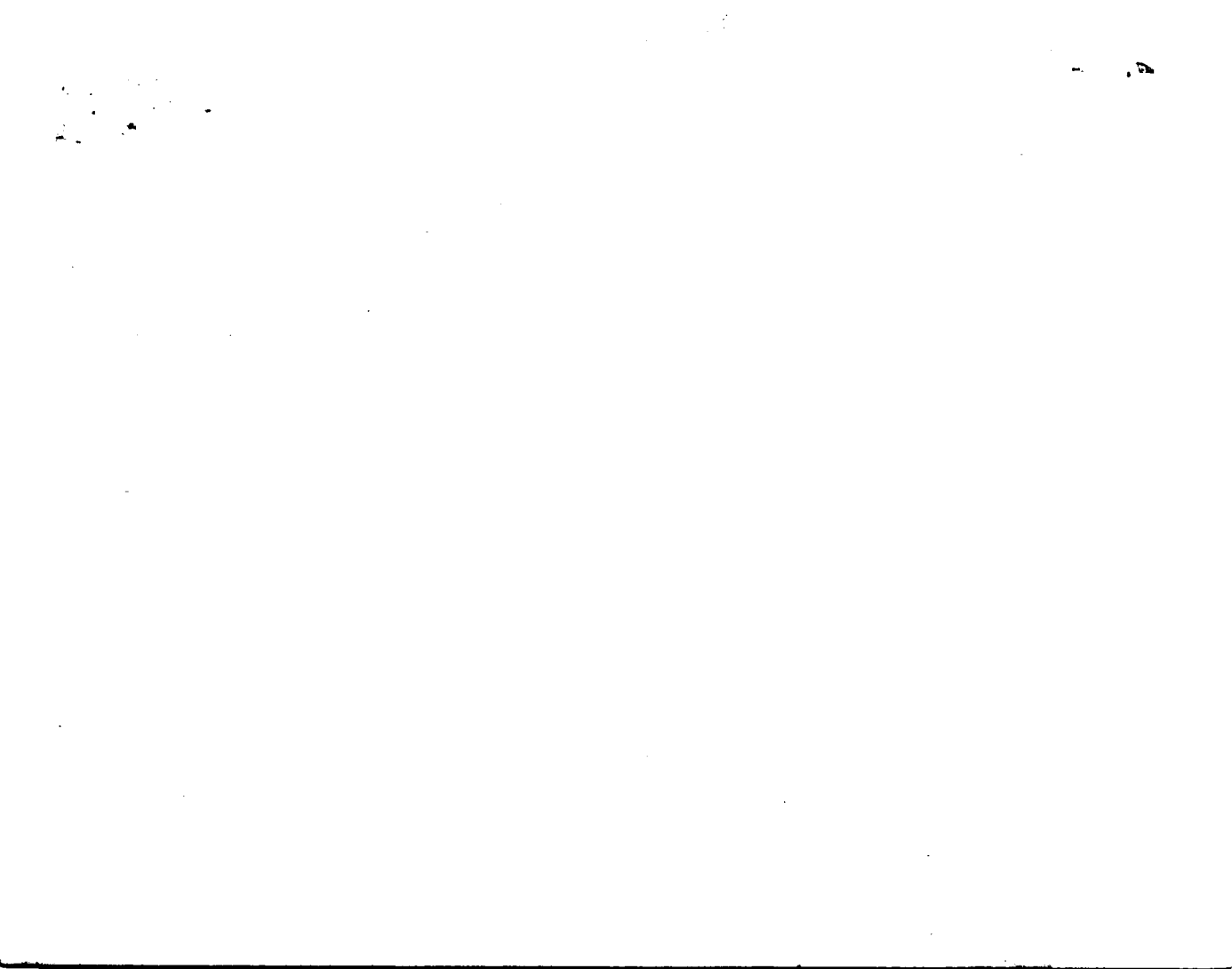
(Physician or midwife)

Give names added from a supplemental report.

Address Pocatello

Filed 12/1 1922 J. H. Young Registrar.

Registrar.





## CERTIFICATE OF DEATH

40319

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Bannock* Registration District No. *28*City of *Pocatello* Registration District No. *2161*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*William S. Burnham*File No. *55*Registered No. *3959*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Infant*  
(Write the word.)

## 6. DATE OF BIRTH

*November 12* 19*22*  
(Month) (Day) (Year)

## 7. AGE

*Stillborn*IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

*Infant*

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) *Pocatello Ida.*

## 10. NAME OF FATHER

*L. C. Burnham*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Richmond Utah*

## 12. MAIDEN NAME OF MOTHER

*Minnie Stout*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Nebraska*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*L. C. Burnham*

(Address)

*142 - No 8th*

## 15.

Filed

*11/13*19*22*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*November 12* 19*22*  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from  
*Nov 12* 19*22* to *Nov 12* 19*22*

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

*Stillbirth caused by  
abruptio-placenta.*

(Duration) ..... Yrs..... mos..... ds.

Contributory  
(Secondary)

(Duration) ..... yrs..... mos..... ds.

(Signed)

*Wm. Newton*

M. D.

*Nov 13 1922* (Address) *Pocatello Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs..... mos..... days In the State ..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Mountain View Cem*

## DATE OF BURIAL

*Nov 13 1922*

## 20. UNDERTAKER

*Schmoecher & Hall*

## ADDRESS

*Pocatello*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

215-125-1003-154  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

RECEIVED  
DEC 30 1922  
BUREAU OF VITAL STATISTICS  
#2161  
84

CERTIFICATE OF BIRTH 107280

County of Blaine  
City of Way  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 84  
Registered No. \_\_\_\_\_

FULL NAME OF CHILD Bely Banks  
(Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>Y</u>	Date of birth <u>11-25-1922</u> (Month) (Day) (Year)
What bacteriocidal solution was used in eyes? <u>Arg 200/10</u>				
Number of child of this mother, including present birth... <u>1</u>		Number of children of this mother now living, including present birth... <u>0</u>		
FATHER FULL NAME <u>Wesley Banks</u>		MOTHER FULL MAIDEN NAME <u>Lucy Anderson</u>		
RESIDENCE <u>Way</u>		RESIDENCE <u>Way</u>		
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)	
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Sugar Utah</u>		
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Heid.</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Shelton at 10:30 PM  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Wesley Banks

Give names added from a supplemental report.

(Physician or midwife)

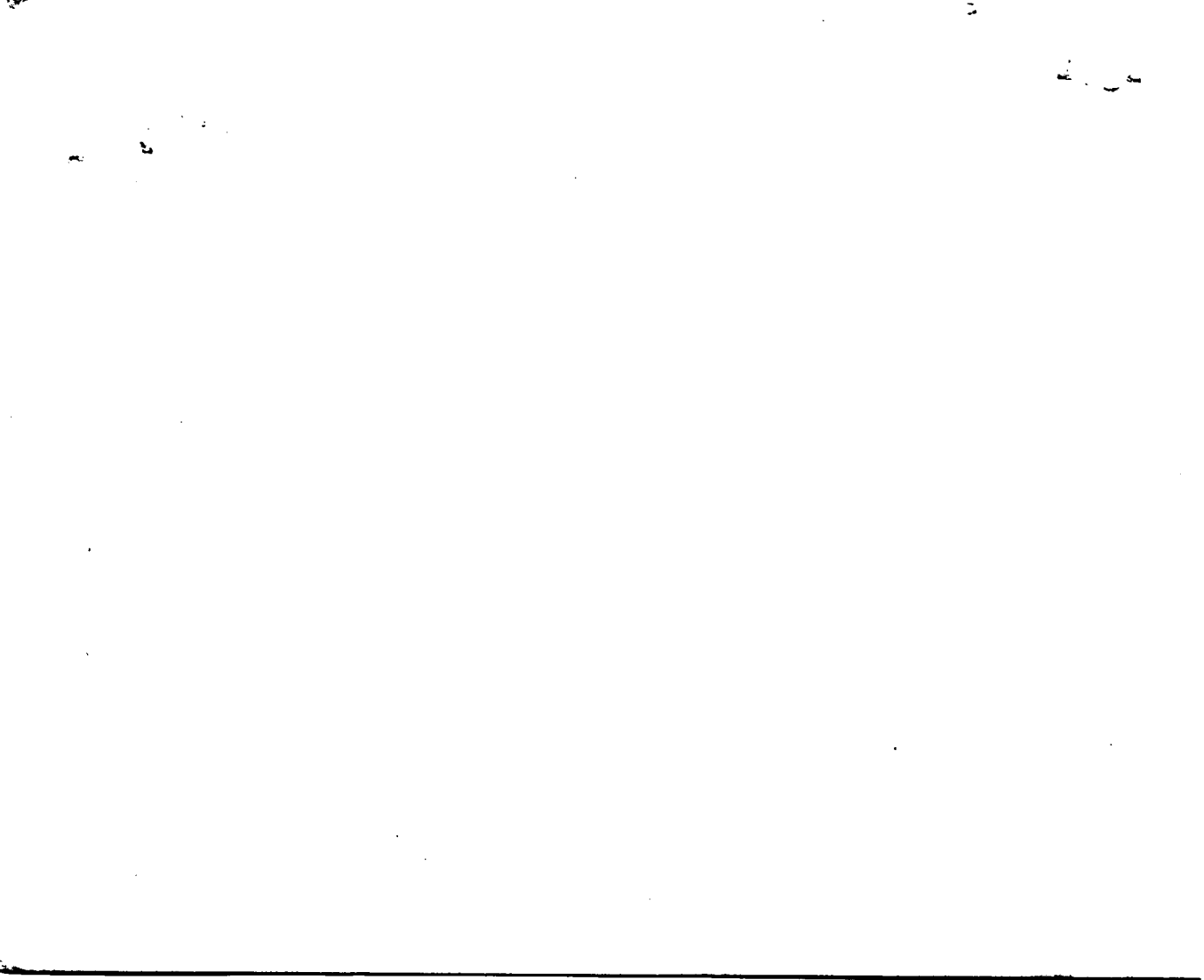
Address Blaine

Filed 12-1-1922 Wesley Banks

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 2161  
County of Bancroft Primary Registration District No. 84  
City of Bancroft (No. 1025) (St.)

File No. 40309

Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Betty Barker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED \_\_\_\_\_  
(Write the word.)

## 6. DATE OF BIRTH

Nov 25 1922  
(Month) (Day) (Year)

## 7. AGE

\_\_\_\_ Yrs. \_\_\_\_ Mos. \_\_\_\_ ds.

IF LESS than 1 day  
how many \_\_\_\_ hrs.  
or \_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

Wade Barker

## 11. BIRTHPLACE OF FATHER

(State or Country) Idaho

## 12. MAIDEN NAME OF MOTHER

Lucy Anderson

## 13. BIRTHPLACE OF MOTHER

(State or Country) Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

## 15.

Filed 1-21- 1922

Walter E. Barker  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Nov 25 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_,  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) \_\_\_\_ Yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_ ? \_\_\_\_\_

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Walter E. Barker M. D.

19\_\_\_\_ (Address) Bancroft, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ days. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ days.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Way, Idaho

\_\_\_\_\_ 19\_\_\_\_

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

154-106003-219

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of Bannock

City of Central

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

RECEIVED  
DECEMBER 1922  
BUREAU OF VITAL STATISTICS  
Primary Registration District No. 84

Registration District No. 2161

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

S  
107284

Sex of Child <u>M.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>11-6</u> (Month) (Day) (Year) <u>1922</u>
------------------------	---	-----	--------------------------------	----------------------------	--

FULL NAME <u>Oliver Anderson</u>	FATHER
RESIDENCE <u>Central</u>	
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Central</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Lois Barber</u>	MOTHER
RESIDENCE <u>Central</u>	
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Whitney Ida</u>	
OCCUPATION <u>H.W.</u>	

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 10 P.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. B. B.

(Physician or midwife)

Given names added from a supplemental report.

Address \_\_\_\_\_

Filed 12-1 1922 W. B. B.

Registrar

Registrar

10744

CERTIFICATE OF BIRTH

City of San Antonio  
County of Brewster  
State of Texas  
Date of Birth 10/10/1910  
Place of Birth San Antonio, Texas  
Sex Male  
Color White  
Height 5' 10"  
Weight 150 lbs  
Build Medium  
Eyes Blue  
Hair Brown  
Mouth Normal  
Nose Normal  
Ears Normal  
Teeth Normal  
Fingerprints Normal  
Signature of Father [Signature]  
Signature of Mother [Signature]  
Signature of Registrar [Signature]  
Date of Registration 10/10/1910  
Place of Registration San Antonio, Texas  
Occupation Student  
Birthplace San Antonio, Texas  
Age at last birthday 10  
Age at last birthday (Years) 10  
Distance 0  
Occupation Student

Number of children of the mother 1  
Number of children of the father 1  
Name of mother [Name]  
Name of father [Name]  
Name of child [Name]  
Date of birth 10/10/1910  
Place of birth San Antonio, Texas  
Sex Male  
Color White  
Height 5' 10"  
Weight 150 lbs  
Build Medium  
Eyes Blue  
Hair Brown  
Mouth Normal  
Nose Normal  
Ears Normal  
Teeth Normal  
Fingerprints Normal  
Signature of Father [Signature]  
Signature of Mother [Signature]  
Signature of Registrar [Signature]  
Date of Registration 10/10/1910  
Place of Registration San Antonio, Texas  
Occupation Student  
Birthplace San Antonio, Texas  
Age at last birthday 10  
Age at last birthday (Years) 10  
Distance 0  
Occupation Student



DEC 30 1922

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHState of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH Bureau of Vital Statistics  
 County of Bannock Primary Registration District No. ....  
 City of Centerville (No. .... St.)

File No. 40308

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betsy Anderson

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
 (Write the word.)

6. DATE OF BIRTH 11-6-1922  
 (Month) (Day) (Year)

7. AGE Yrs. Mos. ds. IF LESS than 1 day  
 how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Idaho10. NAME OF FATHER Oliver Anderson

## 11. BIRTHPLACE OF FATHER

(State or Country) Idaho12. MAIDEN NAME OF MOTHER Leola Barber

## 13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

## 15.

Filled 12-1 19 22 W. B. Barber  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11-6-1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
 ..... 19..... to ..... 19.....  
 that I last saw h..... alive on..... 19.....  
 and that death occurred on the date stated above, at..... M.  
 The CAUSE OF DEATH\* was as follows:

Pneumonia (bacterial)  
 (Duration) ..... Yrs. .... mos. .... ds.  
 Contributory (Secondary) .....  
 (Duration) ..... yrs. .... mos. .... ds.  
 (Signed) W. B. Barber M. D.  
 19..... (Address) Bannock Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Centerville Idaho

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

295-170-006-615  
PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bingham

JAN 3 1923

CERTIFICATE OF BIRTH

107427

City of Moreland

Registration District No. 121

File No.

No. \_\_\_\_\_ St.

Primary Registration District No. 2194

Registered No. 503

Hospital \_\_\_\_\_

Primary Registration District No. 2194

Registered No. 503

FULL NAME OF CHILD

Lowell W. Bingham

(Certificate of no value without full name of child.)

Sex of Child

Male

Twins  
Triplet  
or other?

1 and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti-  
mate?

yes

Date of  
birth

Dec 30 1922

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth. 4

Number of child of this mother now living, including present birth. 3

FULL  
NAME

E. Edward Bingham

FATHER

FULL  
MAIDEN  
NAME

Emma Wangsgard

MOTHER

RESIDENCE

Moreland

RESIDENCE

Moreland

COLOR

White

AGE AT LAST  
BIRTHDAY

34  
(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

31  
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Utah

OCCUPATION

Teacher

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

Stillborn at \_\_\_\_\_ M.  
(Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

W. W. Beck

(Physician or midwife)

Give names added from a supplemental report.

Address

Blackfoot, Idaho

Filed

Dec 30 1922 Mr. Walter C. Latimer

Registrar.

Registrar.



RECEIVED

JAN 12

BUREAU

ST.

STATE OF IDAHO.  
DEPARTMENT OF PUBLIC WELFARE.Boise, Idaho JAN 12 1922.

Dear Madam:

The name of your baby was not filed in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

\*\*\*\*\*

Place of Birth ( City Moranda File No. 107427  
( St. \_\_\_\_\_ Date of Birth Dec 31  
( County Bingham Sex of Child Male  
Father E. Elmer Bingham Mother Emma W. Bingham

I HEREBY CERTIFY that the child herein has been named:

Lowell E. W. BinghamMrs Emma W. Bingham

Signature of Father or Mother.



## 1. PLACE OF DEATH

County of Bingham  
City of Mostrand

If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
JAN 8 1923  
VITAL

## CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 2194

(No. \_\_\_\_\_ St.)

40385

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. \_\_\_\_\_

Registered No. 190

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

Unnamed Bingham

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDMale White Single  
(Write the word.)

6. DATE OF BIRTH

Dec 30 1922  
(Month) (Day) (Year)

7. AGE

Stillborn  
Yrs. mos. ds. IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

E. Edward Bingham

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Emma Wangsgard

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. Edes Bingham

(Address)

Blackfoot # 7

15.

Filed

Dec 30 1922 Wm. H. E. Putney

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

189-6

16. DATE OF DEATH

Dec 30 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 30 1922 to Dec 30 1922that I last saw h. alive on Stillborn 19.and that death occurred on the date stated above, at 8:10 P.

The CAUSE OF DEATH\* was as follows:

Stillborn  
Prolapsed Cord

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

W. W. Beck M. D.12/30 19. (Address) Blackfoot Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Riverside Thomas Cem12/31 19. 22

20. UNDERTAKER

ADDRESS

E. L. EgleBlackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation). using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



165

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County

City

No.

## CERTIFICATE OF BIRTH

File No.

107450

Hospital

Primary Registration District No.

2022

Registered No.

115

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child

Male

Twin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti-  
mate?

Yes

Date of  
birth

11-19

1922

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

6

FULL  
NAME

FATHER

Frank D. Jones

FULL  
MAIDEN  
NAME

MOTHER

Betty Gardner

RESIDENCE

Beaumont, Ida

RESIDENCE

Beaumont, Ida

COLOR

white

AGE AT LAST  
BIRTHDAY

42

(Years)

COLOR

white

AGE AT LAST  
BIRTHDAY

35

(Years)

BIRTHPLACE

North Carolina

BIRTHPLACE

Virginia

OCCUPATION

Farmer

OCCUPATION

Housewife

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was.....  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Robert H. Wright-M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Hailey, Ida

Filed

11-20-22

Robert H. Wright

Registrar.

Registrar.



DEC 16 1975

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

659-116-018-699  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
RECEIVED JAN 9 1923  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

County of Canyon

City of Notus

No. St.

Hospital

Registration District No. 3

File No. 107586

Primary Registration District No. 2005

Registered No. 254

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child	Male	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	Yes	Date of birth	12/16	1923
(To be answered only in event of plural births)							(Month)	(Day)	(Year)

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth... 10..... Number of child of this mother now living, including present birth... 9.....

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
Herman Weick	Notus, Idaho	Caroline Fritz	Notus, Idaho
COLOR	AGE AT LAST BIRTHDAY	COLOR	AGE AT LAST BIRTHDAY
White	46 (Years)	White	41 (Years)
BIRTHPLACE	OCCUPATION	BIRTHPLACE	OCCUPATION
Germany	Farming	Nebraska	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... stillborn... at... 8... A... M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. M. Kaley

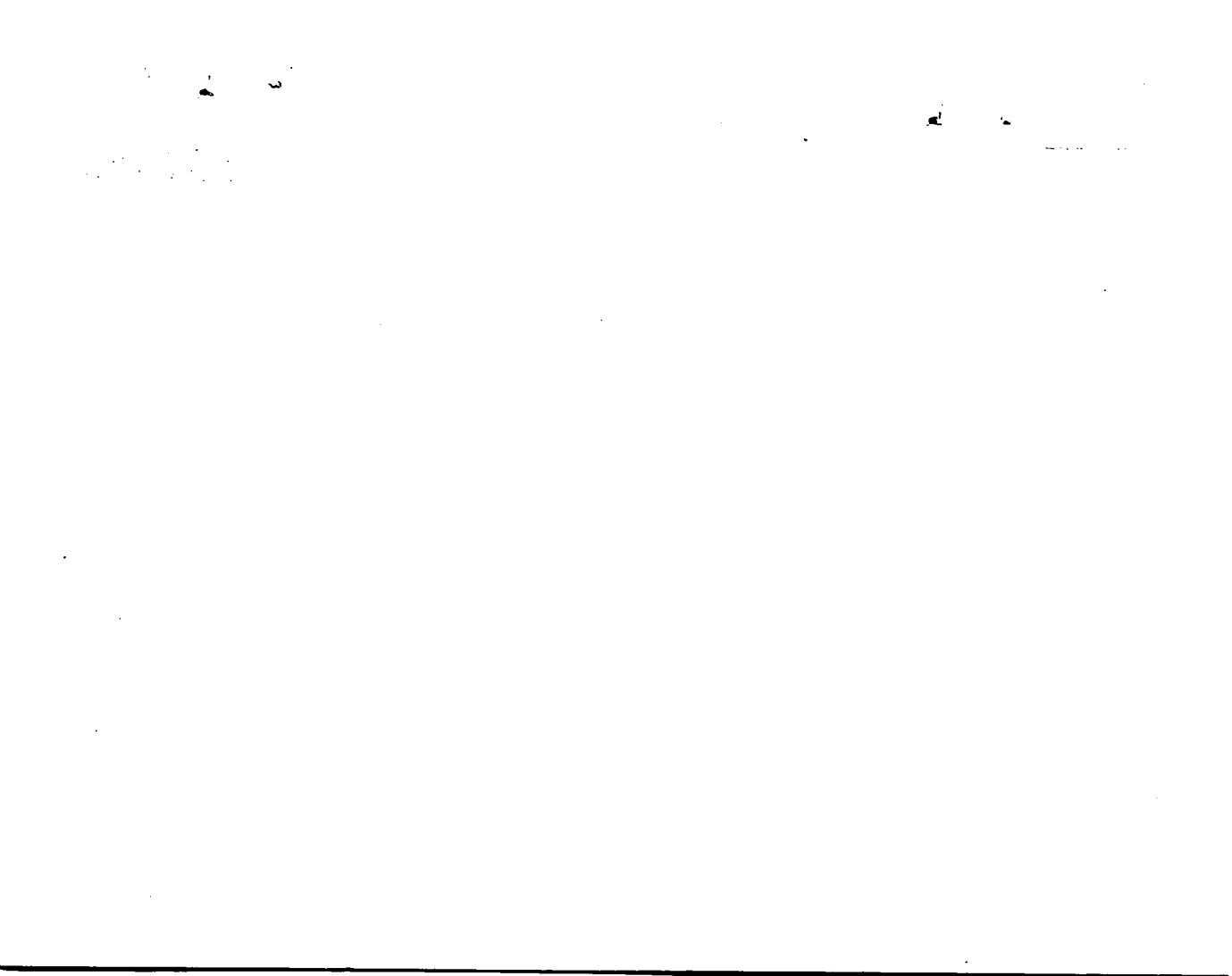
(Physician or midwife)

Give names added from a supplemental report.

Address Caldwell, Idaho

Filed Dec. 17-1922 John H. Meyer Registrar.

Registrar.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **40481**  
Registered No. **135**

## 1. PLACE OF DEATH

County of **Canyon**  
City of **Notus**

Registration District No. **3**  
Primary Registration District No. **2005**  
St. **Idaho**

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Infant Weick**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

**male white**

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

**Dec 16 1922**  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

**Idaho**

## 10. NAME OF FATHER

**Hermann Weick**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Germany**

## 12. MAIDEN NAME OF MOTHER

**Carolina Fritz**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Nebraska**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**Hermann Weick**

(Address)

**Notus, Ida.**

## 15.

Filed **Dec. 16 1922**

**John H. Meyer**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Dec 16 1922**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **12-16 1922** to **12-16 1922** that I last saw him alive on **12-16 1922** and that death occurred on the date stated above, at **8-9 A.M.** The CAUSE OF DEATH\* was as follows:

**Sick from heart to cerebral artery**  
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Canyon Hill 12-16 1922**

## 20. UNDERTAKER

## ADDRESS

**C. V. Beckham Caldwell**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia". (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

815-122-014-2357

PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

S

County of CanyonCity of Hamper

RECEIVED

JAN 5 1923

No. 104-1200 St.Registration District No. 7File No. 107628Hospital MercyPrimary Registration District No. 1006

Registered No.

FULL NAME OF CHILD

Hangar

Sex of Child

maleBorn  
Triplet ☒ and  
or other? ☐  
(To be answered only in event of plural births)Number  
in order  
of birth ☒Legiti-  
mate? ☒Date of  
Birth12-22  
(Month) (Day)1922  
(Year)FULL  
NAME

FATHER

J. Richard HangarFULL  
MAIDEN  
NAME

MOTHER

Grace Kleist

RESIDENCE

RESIDENCE

523-17<sup>th</sup> Ave So523-17<sup>th</sup> Ave So

COLOR

AGE AT LAST  
BIRTHDAY37  
(Years)

COLOR

AGE AT LAST  
BIRTHDAY27  
(Years)

BIRTHPLACE

Illinois

BIRTHPLACE

Iowa

OCCUPATION

Merchant

OCCUPATION

HousewifeNumber of child of this mother, including present birth 2Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.Will Barn at 4<sup>th</sup> Ave M.  
(Born alive or stillborn)

(Signature)

Leo W Chittos

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Hamper Idaho

Filed

Dec. 30 1922 Pearle Dodds

Registrar.

Registrar.

In case of more than one child a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

State not shown as from  
 children divided to show in (1) for to previous and one

Registered No

Temporary Registration No

Homeless

FULL NAME OF CHILD

Child

FULL NAME

FATHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

AGE AT LAST BIRTHDAY

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth. Number of children of this mother now living, including present birth.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

(State alive or stillborn)

on the date above stated

When there was no attending physician or midwife then the father, householder, etc. should not be mentioned. A stillborn child is one that has been born not showing other evidence of life after birth.

(When names added from a supplemental report)

12

Register

Filed

12

Register



# STATE OF IDAHO.

## DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

1923

1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

\* \* \* \* \*

Place of Birth (CITY \_\_\_\_\_)

FILE NO. 107628

of (ST. \_\_\_\_\_)

DATE OF BIRTH \_\_\_\_\_

Birth (COUNTY \_\_\_\_\_)

SEX OF CHILD Male

FATHER \_\_\_\_\_

MOTHER \_\_\_\_\_ (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Baby was born dead. Child was not named.

J. H. Angen,

Signature of Father or Mother.

*[The page contains extremely faint, illegible markings and noise.]*

## CERTIFICATE OF DEATH

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. **40434**

## 1. PLACE OF DEATH

Registration District No. **7**  
 County of **Blaine** JAN 5  
 Primary Registration District No. **1006**  
 City of **Nampa** IDAHO No. \_\_\_\_\_ St.)

Registered No. \_\_\_\_\_

If death occurs away from  
 usual residence, give facts  
 called for under special in-  
 formation.

## 2. FULL NAME

*Infant Hangan*

If death occurred in a hos-  
 pital, institution or camp,  
 give its NAME instead of  
 street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED  
 (Write the word.)

## 6. DATE OF BIRTH

*Dec. 22 1922*  
 (Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or  
 particular kind of work  
 (b) General nature of in-  
 dustry, business or estab-  
 lishment in which employ-  
 ed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

5. Died *Dec. 30 1922*

*Pearle Dadda*  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Dec 22 1922*  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
*12/22/22* 19, to *12/22/22* 19.

that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Still Born - premature*  
*(Sins.)*

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Leo W Chittam* M. D.

*12/21/22* (Address) *Nampa Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted  
 if not at place of death?

Former or  
 usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Nampa Ida* *12/22/22*

## 20. UNDERTAKER

## ADDRESS

*H. H. Emerson* *Nampa Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

659-126-008-789  
PLACE OF BIRTH

County of Clearwater  
City of Ashcroft

RECEIVED  
JAN 9 1923

BUREAU OF VITAL  
STATISTICS

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-22a-2-2-27

S

File No. 107692

No. .... St.

Primary Registration District No. 2168

Registered No. 80

Hospital .....

FULL NAME OF CHILD Harold Ferguson

Sex of Child <u>Male</u>	Twin Triplet or other? <u>    </u>	and { Number in order of birth <u>    </u> }	Legitimate? <u>Yes</u>	Date of Birth <u>Oct 30</u> <u>1922</u>
(To be answered only in event of plural births)			(Month) (Day) (Year)	

FATHER  
FULL NAME Geo M Ferguson  
RESIDENCE Ashcroft  
COLOR White AGE AT LAST BIRTHDAY 47 (Years)  
BIRTHPLACE Canada  
OCCUPATION Rancher

MOTHER  
FULL MAIDEN NAME Beulah Phillips  
RESIDENCE Ashcroft  
COLOR White AGE AT LAST BIRTHDAY 37 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Housewife

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth     

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was ..... at 11 P M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. M. Houswife  
(Physician or midwife)

Given names added from a supplemental report.

Address     

File No. 107692  
Registrar John J. ...



RECEIVED

## CERTIFICATE OF DEATH

E W Korman

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH, Chauvath Registration District No. 90  
 County of Chauvath Primary Registration District No. 2168  
 City of Chauvath (No. \_\_\_\_\_, \_\_\_\_\_ St.)

File No. 40495  
 Registered No. 57

If death occurs away from us-  
 al residence, give facts called  
 for under special information.

## 2. FULL NAME

Harold Ferguson

If death occurred in a hospital, in-  
 stitution or camp give its NAME  
 instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED. Baby  
 (Write the word.)

6. DATE OF BIRTH Oct 26 1922  
 (Month) (Day) (Year)

7. AGE Still Born IF LESS than 1 day  
 how many \_\_\_\_\_ hrs. or  
 \_\_\_\_\_ min?

## 8. OCCUPATION

- (a) Trade, profession or  
 particular kind of work.  
 (b) General nature of industry  
 business or establishment in  
 which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER Geo W Ferguson

11. BIRTHPLACE OF FATHER Idaho  
 (State or Country)

12. MAIDEN NAME OF MOTHER Betha Phillips

13. BIRTHPLACE OF MOTHER Wash.  
 (State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. W. Korman  
 (Address) Chauvath

15. Filed Jan 6 1923 J. M. Sailer  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 26 1922  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
at birth, to Oct 26 1922

that I last saw h. Oct alive on 1922

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still born

\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
 (Secondary)

\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) E. W. Korman M. D.  
10/26 1922 (Address) Chauvath

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)  
 MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place \_\_\_\_\_ In the  
 of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted,  
 If not at place of death?  
 Former or  
 usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Orofino Ida Oct 27 1923

20. UNDERTAKER ADDRESS

none

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



239-2191022-295

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of

Fremont

CERTIFICATE OF BIRTH

City of

St Anthony

Registration District No.

99

File No.

S 107745

No.

St.

Primary Registration District No.

2177

Registered No.

52

Hospital

FULL NAME OF CHILD

Sex of  
Child

7

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

{ and }

Number  
in order  
of birth  
(To be answered only in event of plural births)Legiti  
mate?

yes

Date of  
Birth12-19-1927  
(Month) (Day) (Year)FULL  
NAME

John Simpson

FATHER

RESIDENCE

St Anthony

COLOR

W

AGE AT LAST  
BIRTHDAY40  
(Years)

BIRTHPLACE

Hooper, W.

OCCUPATION

Farmer

FULL  
MAIDEN  
NAME

Sadie Singleton

MOTHER

RESIDENCE

St Anthony

COLOR

W

AGE AT LAST  
BIRTHDAY37  
(Years)

BIRTHPLACE

Hot Springs, W.

OCCUPATION

Housewife

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Stillborn

(Born alive or stillborn)

at 10 P. M.

on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. E. Metton

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

Jan 4<sup>th</sup> 1923

1923

H. M. Hansen

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

10-10-1944

FORM V. S. No. 5-25 M. 1-19.

## 1. PLACE OF DEATH

County of FremontCity of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## RECEIVED CERTIFICATE OF DEATH

Registration District No. 99Primary Registration District No. 2177

(No. State)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 40519Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

M

## 4. COLOR OR RACE

W

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

December 19 1922  
(Month) (Day) (Year)

## 7. AGE

— Yrs. — Mos. — ds.IF LESS than 1 day  
how many — hrs.  
or — min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)None

## 9. BIRTHPLACE

(State or Country)

St. Anthony Idaho

## 10. NAME OF FATHER

John Simpson

## 11. BIRTHPLACE OF FATHER

(State or Country)

Utah

## 12. MAIDEN NAME OF MOTHER

Sarah E Singleton

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. Simpson

(Address)

St. Anthony Idaho

## 15.

Filed

12/201922D. M. Hansen  
Local Registrar

## 16. DATE OF DEATH

12 - 19 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

12-19-1922, to 12-19-1922  
that I last saw him alive on 12-19-1922  
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH\* was as follows:

Premature(Duration) — Yrs. — mos. — ds.Contributory  
(Secondary)(Duration) — yrs. — mos. — ds.

(Signed)

J. E. Miller M. D.12-20-1922 (Address) St. Anthony Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Buried in St. Anthony 12-20-1922

## 20. UNDERTAKER

## ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

299-122-024-614

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH  
County of Gooding  
City of Gooding  
Registration District No. 24 File No. \_\_\_\_\_  
St. Idaho  
Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
Hospital \_\_\_\_\_  
FULL NAME OF CHILD Sizemore. Premature Labor.  
Sex of Child male Twin Triplet or other? and Number in order of birth Legiti mate? yes Date of Birth Dec 22, 1922  
(To be answered only in event of plural births) (Month) (Day) (Year)

FULL NAME <u>Walter Sizemore.</u>	FATHER	FULL MAIDEN NAME <u>Mallie Faddis</u>	MOTHER
RESIDENCE <u>Gooding</u>		RESIDENCE <u>Idaho</u>	
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>27</u> (Years)		COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>29</u> (Years)	
BIRTHPLACE <u>Virginia</u>		BIRTHPLACE <u>Virginia</u>	
OCCUPATION <u>Laborer</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*  
I hereby certify that I attended the birth of this child, who was Stillborn, at 11:45 Am.  
on the date above stated. (Born alive or stillborn)  
(Signature) A. J. Verbrugg  
(Physician or midwife)  
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.  
Given names added from a supplemental report. \_\_\_\_\_  
19\_\_\_\_  
Address Gooding Ida.  
Filed 1-10- 1923 J. J. Canino  
Registrar Registrar

207814

City of Gooding  
 County of Gooding  
 No. 4  
 Primary Registration District No. 4  
 Registered No. 4  
 Hospital

FULL NAME OF CHILD William Gooding		Sex of Child Male		Date of Birth Dec 20 1900	
FULL NAME William Gooding		Sex of Child Male		Date of Birth Dec 20 1900	
RESIDENCE Gooding		RESIDENCE Idaho		COLOR White	
BIRTHPLACE Virginia		BIRTHPLACE Virginia		COLOR White	
OCCUPATION Laborer		OCCUPATION Housewife		BIRTHPLACE Virginia	

Number of child of this mother, including present birth 4. Number of children of this mother now living, including present birth 4.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Subscribed and sworn to before me this 11th day of December 1900.

At Gooding, Idaho.

Physician or midwife

Filed

DO NOT SIGN THIS CERTIFICATE FOR ANY CHILD UNLESS YOU ARE A PHYSICIAN OR MIDWIFE. IF YOU ARE A PHYSICIAN OR MIDWIFE, YOU MUST SIGN THIS CERTIFICATE FOR EVERY CHILD BORN IN YOUR DISTRICT. IF YOU ARE A PHYSICIAN OR MIDWIFE, YOU MUST SIGN THIS CERTIFICATE FOR EVERY CHILD BORN IN YOUR DISTRICT.

FORM V. S. No. 5-25 M. 1-19.

## 1. PLACE OF DEATH

County of Gooding  
City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sizemore.

## CERTIFICATE OF DEATH

Registration District No. 24Primary Registration District No. 24(No. ✓ St.)Premature labor.State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 40537Registered No. 1516

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED  
single.  
(Write the word.)

## 6. DATE OF BIRTH

12/22/22.

(Month) (Day) (Year)

7. AGE Stillborn.X Yrs. X Mos. X ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work. X

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Idaho.

## 10. NAME OF FATHER

Walter Sizemore.

## 11. BIRTHPLACE OF FATHER

(State or Country) Virginia

## 12. MAIDEN NAME OF MOTHER

Mallie Faddis

## 13. BIRTHPLACE OF MOTHER

(State or Country) Virginia

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed 1-10-1923J. E. Cary, MD  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

December 22, 1922

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
Dec 22, 1922, to 19that I last saw h. XX have on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Premature laborStillborn.(Duration) Yrs. mos. ds.Contributory  
(Secondary)(Duration) Yrs. mos. ds.(Signed) J. E. Cary, MD M. D.Gooding Ida.  
19 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

19

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

713-117-226-366

PLACE OF BIRTH

Still Born

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

107853

County of Jefferson

City of \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

RECEIVED CERTIFICATE OF BIRTH

DEC 30 1922

Registration District No. 18

File No. \_\_\_\_\_

Primary Registration District No. 2176

Registered No. 321

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Boy</u>	Twin <input checked="" type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other <input checked="" type="checkbox"/> { and } Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Sept 17</u> 192 <u>2</u> (Month) (Day) (Year)
-------------------------	---	------------------------	---

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FATHER  
FULL NAME W. D. Galles  
RESIDENCE Idaho  
COLOR white AGE AT LAST BIRTHDAY 36 (years)  
BIRTHPLACE Idaho  
OCCUPATION farmer

MOTHER  
FULL MAIDEN NAME Paula E. Lowder  
RESIDENCE Idaho  
COLOR white AGE AT LAST BIRTHDAY 31 (years)  
BIRTHPLACE Idaho  
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

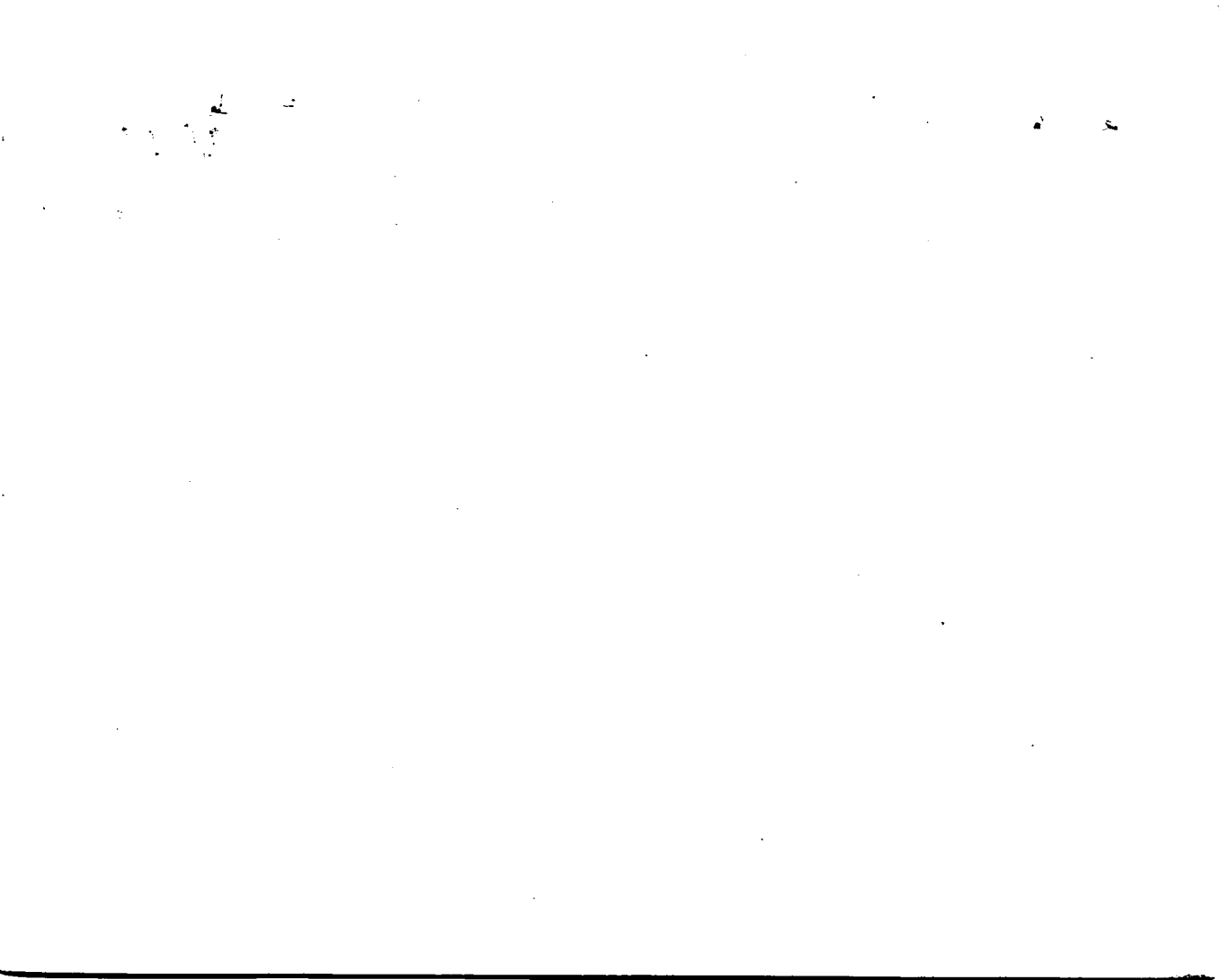
I hereby certify that I attended the birth of this child, who was Stillborn, at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Sam A. Price  
Physician  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Idaho  
Filed 12-10 1922 Ray H. Fisher  
Registrar.



## 1. PLACE OF DEATH

County of Jefferson  
City of Ririe

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED single  
(Write the word.)

6. DATE OF BIRTH

Sept 17 1922  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (for employer)Stillborn

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W.S. Gallup

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MARRIED NAME OF MOTHER

Pearl G. Lowder

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W.S. Gallup

(Address)

Ririe Idaho

15.

Filed

12-10-22 Ray H. Fisher  
Local RegistrarRECEIVED  
DEC 30 1922  
VITAL  
STATISTICSCERTIFICATE OF DEATH  
Registration District No. 98  
Primary Residence District No. 2176  
(No. St.)State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 40552  
Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 17 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Sam J. Price M. D.9-18-22 (Address) Ririe, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

281-103026-266  
PLACE OF BIRTH

RECEIVED

DEC-30 1922

STATE OF IOWA

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS  
BUREAU OF VITAL STATISTICS

S

County of Jefferson

City of Ripley, Ida.

No. St.

Registration District No. 98

File No. 107873

Hospital Home

Primary Registration District No. 2176

Registered No. 303

FULL NAME OF CHILD

Premature

(Certificate of no value without full name of child.)

Sex of Child m

Twin  
Triplet  
or other?

and

Number  
in order  
of birth  
(To be answered only in event of plural births)

Legiti-  
mate? yes

Date of birth 10/3/1922  
(Month) (Day) (Year)

What bactericidal solution was used in eyes? 2.5% sal. Argysol

Number of child of this mother, including present birth 1

Number of children of this mother now living, including present birth 1

FATHER  
FULL NAME John M. Sharp

RESIDENCE Ripley Idaho

COLOR White AGE AT LAST BIRTHDAY 37  
(Years)

BIRTHPLACE Amsterdam Holland

OCCUPATION farmer

MOTHER  
FULL MAIDEN NAME Katherine Bourkeheim

RESIDENCE Ripley Ida

COLOR White AGE AT LAST BIRTHDAY 29  
(Years)

BIRTHPLACE Ogden, Utah

OCCUPATION home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 1940 M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. C. Ball M.D.  
Ripley Idaho  
(Physician or midwife)

Give names added from a supplemental report.

192

Registrar.

Address

Filed 12-10 1922

Ray H. Fisher  
Registrar.

CHILD

Sex of Child

Age at last birthday

Place of birth

Color

Age at last birthday

Age at last birthday

Birth date

Occupation

CERTIFICATE OF ATTENDANCE

Signature of parent

Signature of parent

Signature of parent

1925

Registrar

RECEIVED  
JUN 3 1923  
BUREAU OF VITAL  
STATISTICS

STATE OF IDAHO.  
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho \_\_\_\_\_ 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

\* \* \* \* \*

Place of Birth { CITY Rigby Idaho FILE NO. 107873  
ST. 1 mile out DATE OF BIRTH Oct 3 1922  
COUNTY Lewiston SEX OF CHILD Male  
FATHER John Marine Sharp MOTHER Catherine Bour  
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Child was a premature, still born to  
was not named

John Marine Sharp  
Signature of Father or Mother

[illegible]

10

1. NAME \_\_\_\_\_  
 2. ADDRESS \_\_\_\_\_  
 3. CITY \_\_\_\_\_  
 4. STATE \_\_\_\_\_  
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 219. PRINT CITY \_\_\_\_\_  
 220. PRINT STATE \_\_\_\_\_

CONFIDENTIAL - SECURITY INFORMATION - NO FORN DISSEM

SECRET

*[Faint, illegible handwritten notes]*



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

569-151-027-698  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Jerome  
City of Jerome  
No. 23 Registration District No. 1017 File No. 107900  
Hospital home Primary Registration District No. 2017 Registered No. 1017

FULL NAME OF CHILD

Lennard James Borgard  
(Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twin <u>X</u> Triplet <u>X</u> or other <u>X</u>	and { Number in order of birth 3	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 1</u> 192 <u>2</u> (Month) (Day) (Year)
------------------------	--	--	-----------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

FATHER  
FULL NAME Reils Nargard  
RESIDENCE Jerome, Ida  
COLOR white  
AGE AT LAST BIRTHDAY 213 (Years)  
BIRTHPLACE colo.  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Pearl Fry  
RESIDENCE Jerome, Ida  
COLOR white  
AGE AT LAST BIRTHDAY 29 (Years)  
BIRTHPLACE Ill.  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn 4 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas. F. Zell

Give names added from a supplemental report.

(Physician or midwife)

Address Jerome, Ida

Filed DEC 14 1922 E. D. Piper M.D.

Registrar.

Registrar.

1. This is to certify that the child named above is the child of the mother named above.  
 2. This is to certify that the child named above is the child of the mother named above.  
 3. This is to certify that the child named above is the child of the mother named above.  
 4. This is to certify that the child named above is the child of the mother named above.  
 5. This is to certify that the child named above is the child of the mother named above.  
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 7. This is to certify that the child named above is the child of the mother named above.  
 8. This is to certify that the child named above is the child of the mother named above.  
 9. This is to certify that the child named above is the child of the mother named above.  
 10. This is to certify that the child named above is the child of the mother named above.

Give name above from a supplemental report.

(2) (Signature)

I hereby certify that I attended the birth of this child, and that the child is the child of the mother named above.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

OCCUPATION

BIRTHPLACE

AGE AT LAST BIRTHDAY

COLOR

RESIDENCE

NAME

MOTHER

DATE OF BIRTH

SEX OF CHILD

REGISTERED NO.

HOSPITAL

FULL NAME OF CHILD

RECEIVED

FEB 2 1923

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

JAN 18 1923

Boise, Idaho 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

\*\*\*\*\*

Place of Birth	(CITY) <u>Jerome</u>	FILE NO.	<u>107900</u>
	(ST.) <u>Idaho</u>	DATE OF BIRTH	<u>Aug 1, 1922</u>
	COUNTY <u>Jerome</u>	SEX OF CHILD	<u>Male</u>
	FATHER <u>N. E. Gorgard</u>	MOTHER	<u>Pearl Fry</u>
			(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Lennard James Gorgard  
N. E. Gorgard

Signature of Father or Mother.



FORM V. S. No. 5-25 M. 1-19.

## 1. PLACE OF DEATH

County of JeromeCity of Jerome

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

unnamed Morgard

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

M

## 4. COLOR OR RACE

W

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant

(Write the word.)

## 6. DATE OF BIRTH

Aug 1 22  
(Month) (Day) (Year)

## 7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) Jerome

## 10. NAME OF FATHER

Rich E Morgard

## 11. BIRTHPLACE OF FATHER

(State or Country) Colorado

## 12. MAIDEN NAME OF MOTHER

Paul Fay

## 13. BIRTHPLACE OF MOTHER

(State or Country) Chicago Ill

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

Aug 1 1922 Ed J. Miller M.D.

Local Registrar

RECEIVED

DEC 30 1922

Registration District No. 23Registration District No. 1017-2017

(No.)

St.)

Registered No.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

40555

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Aug 1 22  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 1922 to Aug 1 1922that I last saw him alive on Aug 1 1922and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. F. Zeller M.D. by E. D. P.B. I. 1922

(Address)

Jerome Id.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Jerome CemeteryAug 1 1922

## 20. UNDERTAKER

## ADDRESS

Rich E. MorgardJerome17 Allen St.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

485-114-027-962  
PLACE OF BIRTH

RECEIVED  
DEC 30 1922  
HOSPITAL

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

107901

County of Jerome  
City of Jerome  
No. 23 St. 1017 Registration District No. 2-017 File No. 107901  
Hospital Home Primary Registration District No. 2-017 Registered No. 107901

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twin <u>no</u> Triplet <u>no</u> or other? <u>no</u> and {Number in order of birth <u>1</u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>Aug 14</u> 192 <u>2</u> (Month) (Day) (Year)
------------------------	---	------------------------	---

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth...7 Number of children of this mother now living, including present birth...6

FATHER  
FULL NAME Walter E. Myers  
RESIDENCE Jerome, Ida.  
COLOR white AGE AT LAST BIRTHDAY 34 (Years)  
BIRTHPLACE Arkansas  
OCCUPATION Farming

MOTHER  
FULL MAIDEN NAME Laura Roberts  
RESIDENCE Jerome, Ida.  
COLOR white AGE AT LAST BIRTHDAY 32 (Years)  
BIRTHPLACE Mo.  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated. (Born alive or stillborn) 11/11

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas. T. Zeller  
M.D.  
(Physician or midwife)

Give names added from a supplemental report.  
....., 192.....

Address Jerome, Ida.  
Filed Dec 14 1922 E. D. Piper M.D.  
Registrar.

(GIVEN IN THE STATE OF CALIFORNIA)  
 I, the undersigned, being a duly qualified and licensed midwife, do hereby certify that the child named above was born on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_, California, and that the child was born alive and was born with the following characteristics: \_\_\_\_\_  
 I have signed this certificate and the accompanying record book at \_\_\_\_\_, California, on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Registered \_\_\_\_\_  
 Address \_\_\_\_\_  
 Filed \_\_\_\_\_  
 193

**CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE\***

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
 (Signature of Midwife)  
 \_\_\_\_\_  
 (Signature of Physician)  
 \_\_\_\_\_

OCCUPATION \_\_\_\_\_  
 BIRTHPLACE \_\_\_\_\_  
 AGE AT LAST BIRTHDAY \_\_\_\_\_  
 COLOR \_\_\_\_\_  
 RESIDENCE \_\_\_\_\_  
 NAME OF CHILD \_\_\_\_\_  
 SEX OF CHILD \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_  
 PLACE OF BIRTH \_\_\_\_\_  
 REGISTERED NO. \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_  
 SEX OF CHILD \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_  
 PLACE OF BIRTH \_\_\_\_\_  
 REGISTERED NO. \_\_\_\_\_

COUNTY OF \_\_\_\_\_  
 STATE OF \_\_\_\_\_  
 PLACE OF BIRTH \_\_\_\_\_



STATE OF IDAHO.  
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho JAN 10 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

\*\*\*\*\*

Place of Birth (CITY \_\_\_\_\_  
ST. \_\_\_\_\_  
COUNTY \_\_\_\_\_  
FATHER \_\_\_\_\_  
MOTHER \_\_\_\_\_

FILE NO. 107901  
DATE OF BIRTH \_\_\_\_\_  
SEX OF CHILD Male  
MOTHER \_\_\_\_\_  
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named: \_\_\_\_\_

Signature of Father or Mother.

RECEIVED  
 DEPARTMENT OF THE ARMY  
 WASHINGTON, D. C.

1953

Dear Madam:

The Department of the Army is pleased to inform you that your application for a position in the Department of the Army has been received and is being processed. We are currently reviewing your qualifications and will contact you again once a decision has been reached. We appreciate your interest in joining the Department of the Army and look forward to the possibility of working with you.

Sincerely,  
 [Signature]

NAME	_____	DATE	_____
ADDRESS	_____	PHONE	_____
CITY	_____	STATE	_____
COUNTRY	_____	ZIP	_____
REFERENCE	_____		

I HEREBY CERTIFY THAT THE ABOVE INFORMATION HAS BEEN RECEIVED AND IS BEING PROCESSED.

997-227-028-263  
PLACE OF BIRTHSTATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

RECEIVED

JAN 11 1923

## CERTIFICATE OF BIRTH

County of KootenaiCity of Coeur d'Alene

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

107916

Hospital \_\_\_\_\_

Primary Registration District No. 1051Registered No. 1462

FULL NAME OF CHILD

Margaret Riplinger

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Nov. 27</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacterioidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 3Number of children of this mother now living, including present birth... 1

FULL NAME

FATHER

Robert Riplinger

FULL MAIDEN NAME

MOTHER

Verna Amelia Butterell

RESIDENCE

Coeur d'Alene, Ida

RESIDENCE

Coeur d'Alene, Ida

COLOR

white

AGE AT LAST BIRTHDAY

30

(Years)

COLOR

white

AGE AT LAST BIRTHDAY

29

(Years)

BIRTHPLACE

Missi.

BIRTHPLACE

Mich.

OCCUPATION

Carpenter

OCCUPATION

Housewife

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Stillborn30

(Born alive or stillborn)

5 P. M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

J. C. Sawyer  
Physician

(Physician or midwife)

Address \_\_\_\_\_

Coeur d'Alene, Ida

Filed \_\_\_\_\_

1923Dr. J. C. Sawyer

Registrar.

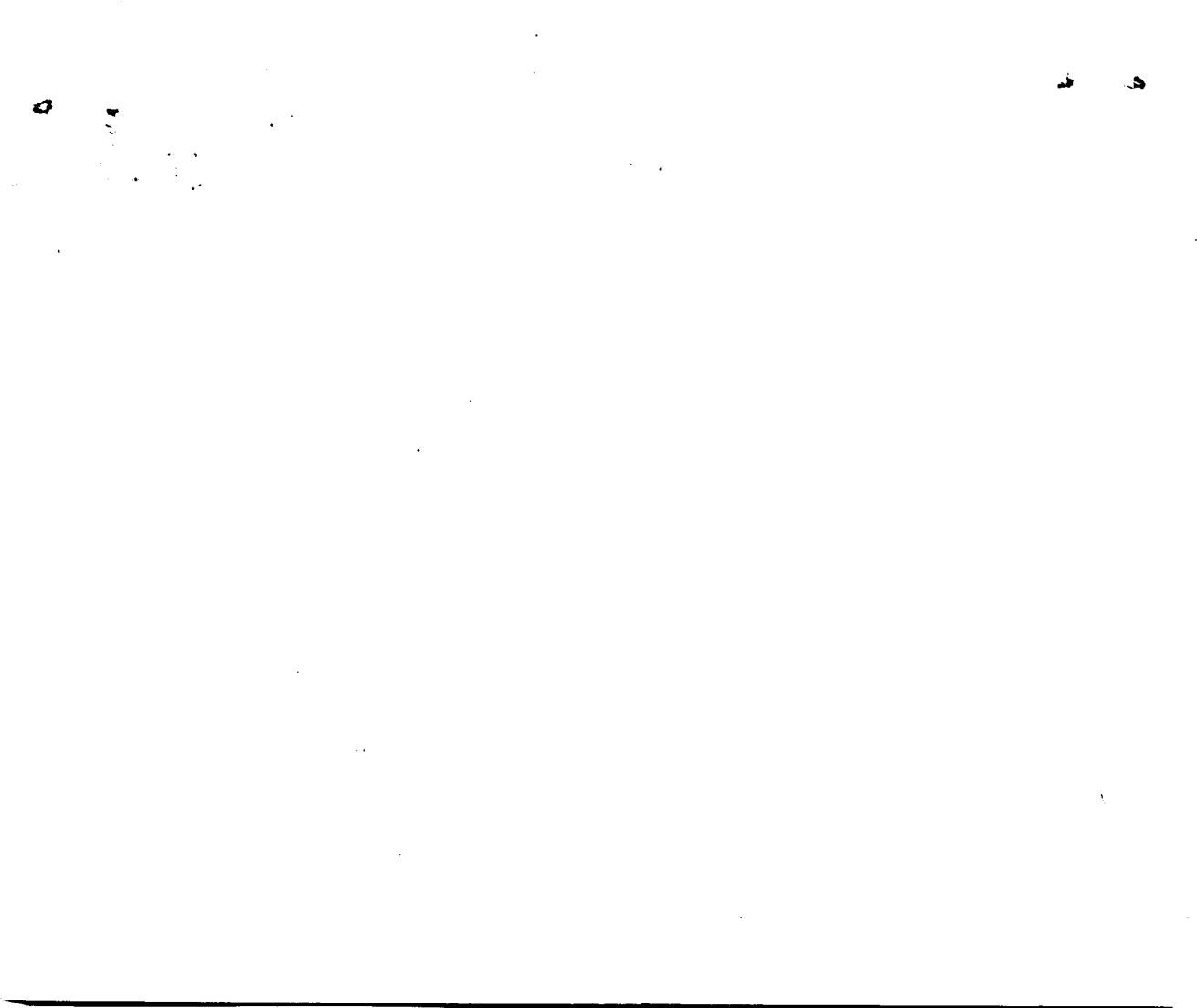
Registrar.

Give names added from a supplemental report.

\_\_\_\_\_, 192\_\_\_\_

\_\_\_\_\_, 192\_\_\_\_

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Boonville  
City of Boonville

Registration District No. 30Primary Registration District No. 105No. 30 St. 105

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Margaret Ripplinger

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 40031  
Registered No. 113-8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

F.

## 4. COLOR OR RACE

W.

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

## 6. DATE OF BIRTH

11 - 27 1922  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Norbert Ripplinger

## 11. BIRTHPLACE OF FATHER

(State or Country)

Wis

## 12. MAIDEN NAME OF MOTHER

Bronica Brottrell

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Mich.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norbert Ripplinger

(Address)

## 15.

Filed Dec. 4 1922

D. D. Brennan  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Nov 27 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Nov 27 1922, to Nov 27 1922

that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillborn Primature  
Death probably occurred several days  
Prior to birth

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

11/28 Nov (Address) Boonville M. D.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

St. Thomas Cem

## DATE OF BURIAL

11-28 1922

## 20. UNDERTAKER

Carsey

## ADDRESS

Boonville

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

239-217-028-236  
PLACE OF BIRTH

REC'D

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Kootenai

City of Coeur d'Alene

No. 1140-5th St.

Registration District No. 30

File No.

CERTIFICATE OF BIRTH

107924

Hospital

Primary Registration District No. 1052

Registered No. 1470

FULL NAME OF CHILD

Irma Edna Stickney

(Certificate of no value without full name of child.)

Sex of Child

Female

Twins  
Triplet  
or other  
(To be entered only in event of plural births)

and

Number  
in order  
of birth one

Legiti-  
mate?

yes

Date of  
birth

Dec 17

1922

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth. 2

Number of child of this mother now living, including present birth. 1

FULL  
NAME

Fred L. Stickney

FULL  
MAIDEN  
NAME

Margaret Isabell Scott

RESIDENCE

Coeur d'Alene

RESIDENCE

Coeur d'Alene

COLOR

White

AGE AT LAST  
BIRTHDAY

32  
(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

25  
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Michigan

OCCUPATION

Truck Driver

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

Bill Horn

8 A

M.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

W. H. Kaedner md

(Physician or midwife)

Give names added from a supplemental report.

Address

Coeur d'Alene Ida.

Filed

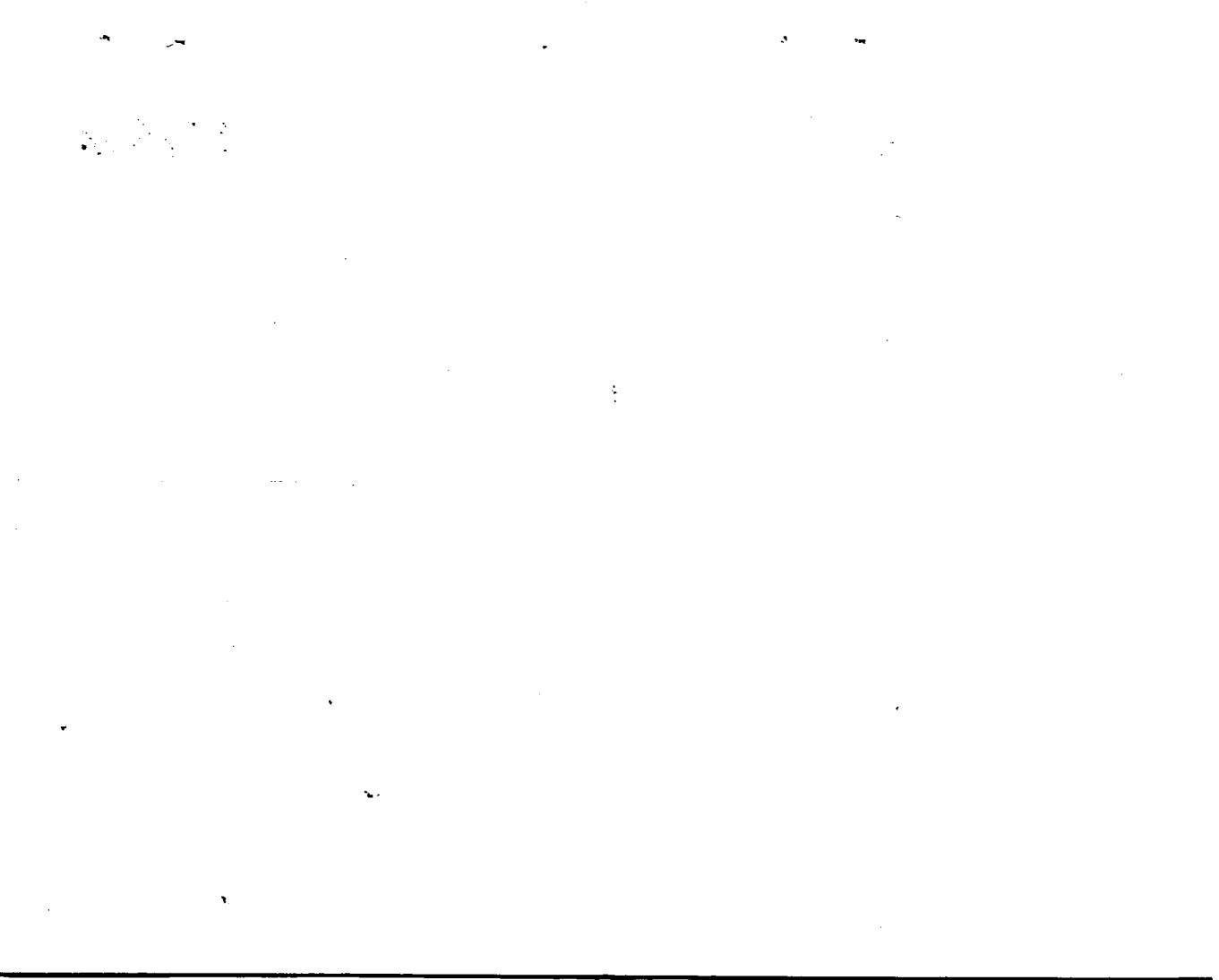
1-6

1923

Ed D. Williams

Registrar.

Registrar.





WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

## CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 40576  
Registered No. 1171

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Stillborn, no known cause.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Hadden M. D.

(Address) Council Bluffs

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem. C. B. A.

12-18-1922

20. UNDERTAKER

ADDRESS

C. Cassidy

C. B. A.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

313123-29-133

Form V. S. No. 11-C—25m-7-21-19

## PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of Latah

DEC 30 1922

## CERTIFICATE OF BIRTH

City of BoothRegistration District No. 65File No. 107939

No. \_\_\_\_\_ St.

Primary Registration District No. 2145 Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD Unnamed - Infant of J. H. Tate

Sex of Child <u>male</u>	Twin Triplet or other? <input checked="" type="checkbox"/>	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>Dec 23 1922</u> (Month) (Day) (Year)
--------------------------	--	-----	--------------------------------	----------------------------	--

FULL NAME <u>J. H. Tate</u>	FATHER
RESIDENCE <u>Booth</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>Oregon</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Ella Allen</u>	MOTHER
RESIDENCE <u>Booth</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Wisconsin</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still - born, at 12 - 1 - M on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. J. Thompson  
in 2  
(Physician or midwife)

Given names added from a supplemental report.

Address Booth 24th  
Filed Nov 1 - 1922 D. J. Thompson  
Registrar

THIS IS A CERTIFICATE OF BIRTH FOR A CHILD BORN AT THE PLACE OF BIRTH OF THE CHILD, AND THE CHILD IS THE CHILD OF THE MOTHER AND FATHER NAMED HEREIN. IT IS IN CASE OF MARRIAGE TO BE KEPT IN THE RECORDS OF THE COUNTY OF BIRTH OF THE CHILD.

STATE OF ILLINOIS  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

PLACE OF BIRTH

107033

County of Franklin  
City of Springfield  
No. 107033  
Registration District No. 107033  
Primary Registration District No. 107033  
Registered No. 107033

Hospital St. Mary's  
FULL NAME OF CHILD John Joseph

Child John Joseph Sex of Male  
(To be answered only in event of plural births)  
and in order of birth  
Number of children born to mother 1  
Last name Smith  
Date of birth (Month) 10 (Day) 15 (Year) 1915

FATHER FULL NAME John Joseph Smith  
MOTHER FULL NAME John Joseph Smith

RESIDENCE St. Mary's

COLOR White AGE AT LAST BIRTHDAY 15 (Years)  
COLOR White AGE AT LAST BIRTHDAY 15 (Years)

BIRTHPLACE St. Mary's BIRTHPLACE St. Mary's

OCCUPATION St. Mary's OCCUPATION St. Mary's

Number of child of this mother, including previous birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  
I hereby certify that I attended the birth of this child, who was born alive or stillborn  
(Signature) John Joseph Smith

(Physician or midwife)  
When there was no attending physician or midwife, then the father, householder, etc., should make this return. A birth record is not valid unless signed by some other person of the father's name.

(Given names signed from a supplemental report)  
is John Joseph Smith

Address St. Mary's  
Filed St. Mary's

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Lululu  
City of Pottsville

Registration District No. 65Primary Registration District No. 2145

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 40596

Registered No. \_\_\_\_\_

If death occurs away from  
usual residence, give facts  
called for under special  
information.

2. FULL NAME

Unmarried Infant: J. H. Tate

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.Male - whiteSingle  
(Write the word.)

6. DATE OF BIRTH.

Oct. 23 1922  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or  
min. None.

8. OCCUPATION

(a) Trade, profession or  
particular kind of work...  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which employ-  
ed (or employer).

None.

9. BIRTHPLACE

(State or Country) - Idaho.

10. NAME OF FATHER

J. H. Tate

11. BIRTHPLACE OF FATHER

(State or Country) Oregon.

12. MAIDEN NAME OF MOTHER

Ella Allen

13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. H. Tate  
Pottsville

15.

Filed Oct. 24 1922J. H. Tate

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 23 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw h. alive on 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still Born -(Duration) ✓ Yrs. ✓ mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Thompson M. D.Oct. 24 1922 (Address) Pottsville Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)  
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death... yrs. mos. days In the State... yrs. mos. days

Where was disease contracted  
if not at place of death?

Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pleasant Bridge CemeteryOct. 25 1922

20. UNDERTAKER

ADDRESS

ParentsPottsville

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

543.126-029-214  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
RECEIVED  
JAN 3 1923  
BUREAU OF VITAL STATISTICS

S  
107976

County \_\_\_\_\_  
City \_\_\_\_\_  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Hospital \_\_\_\_\_  
Primary Registration District No. 2145 Local Registrar's No. \_\_\_\_\_  
FULL NAME OF CHILD Arnold Mulliner.

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>2</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Dec 26</u> , 192 <u>2</u> (Month) (Day) (Year)
--------------------------	---------------------------------	-----	-----------------------------------	------------------------	--

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth <u>4</u>		Number of child of this mother now living, including present birth <u>2</u>	
FATHER FULL NAME <u>Ed. L. Mulliner</u>		MOTHER FULL MAIDEN NAME <u>Elizabeth Baumgardner</u>	
RESIDENCE <u>Pocatello Idaho</u>		RESIDENCE <u>Pocatello Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Indiana</u>		BIRTHPLACE <u>Russia</u>	
OCCUPATION <u>Night watch</u>		OCCUPATION <u>House wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 45 P. M. on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Ernest S. Hine  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 192\_\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Pocatello Idaho  
Filed Dec. 29 1922. D. J. Thompson  
Registrar.

• 3 4 7 1 2 5 6 8



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

713-113-034-215  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Minidoka  
City of Heyburn JAN 1922  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 19 File No. 108032  
Hospital \_\_\_\_\_ Primary Registration District No. 2015 Registered No. 189  
FULL NAME OF CHILD Stillborn  
(Certificate of no value without full name of child.)

Sex of Child <u>m.</u>	Twin Triplet or other? _____	{ and }	Number in order of birth _____	Legitimate? <u>yes.</u>	Date of birth <u>Nov. 13</u> 192 <u>2</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? Silver Nitrate

Number of child of this mother, including present birth... 7 Number of child of this mother now living, including present birth... 5

FATHER	MOTHER
FULL NAME <u>J. J. Patterson</u>	FULL MAIDEN NAME <u>Ethel Sanders</u>
RESIDENCE <u>Heyburn Ida</u>	RESIDENCE <u>Heyburn</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>47</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>North Carolina</u>	BIRTHPLACE <u>Arizona</u>
OCCUPATION <u>Farming</u>	OCCUPATION <u>House-wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... Stillborn, at... 4 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. C. Patterson  
Physician or midwife

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Burley Ida  
Filed Nov. 24 1922 W. E. Elmer  
Registrar.

1. 2

1. 2

1. 2

1. 2

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Minidoka*  
City of *Heyburn*Registration District No. *19*Primary Registration District No. *2013*(No. *3*)

St.)

File No. *40624*Registered No. *52*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

JAN 2 - 1922  
2. FULL NAME of Deceased *Stell born Patterson*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male white**Single*  
(Write the word.)

## 6. DATE OF BIRTH

*Nov. 13 1922*  
(Month) (Day) (Year)

## 7. AGE

*Still born*  
Yrs. Mos. da.IF LESS than 1 day  
how many hrs.  
or 0 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Burley, Ida.*

## 10. NAME OF FATHER

*J. J. Patterson*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*North Carolina*

## 12. MAIDEN NAME OF MOTHER

*Ethel Sanders*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Arizona*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*J. J. Patterson*

(Address)

*Heyburn, Ida.*

## 15.

Filed *Nov. 15 1922*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Dec 13 1922*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

*Still born**Knott in cord.*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*J. C. Patterson* M. D.*11/15 1922* (Address) *Burley, Ida.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Heyburn, Ida.*

## DATE OF BURIAL

*11-14 1922*

## 20. UNDERTAKER

*None*

## ADDRESS

*None*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

558-224.038-624

PLACE OF BIRTH

County of Pavette.

City of Pavette.

No. 505-North 6th. St.

Hospital

FULL NAME OF CHILD Triplets-stillborn-not named.

Sex of Child Three Females Twin Triplets and Number in order of birth 4 Legitmate? Yes Date of Birth Dec. 24, 1922 (Month) (Day) (Year)

FULL NAME FATHER John W. Neyman

RESIDENCE Pavette, Idaho

COLOR White AGE AT LAST BIRTHDAY 50 (Years)

BIRTHPLACE Indiana.

OCCUPATION Salesman

FULL MAIDEN NAME MOTHER Vernie Osmund.

RESIDENCE Pavette, Idaho.

COLOR White AGE AT LAST BIRTHDAY 32 (Years)

BIRTHPLACE Wyoming.

OCCUPATION Housewife

Number of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn, at 1.00 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature) J. C. Woodward, M.D. Physician. (Physician or midwife)

Address Pavette, Idaho.

Filed Dec. 26 1922 J. C. Woodward Registrar

Registrar

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S  
108133

RECEIVED  
DEC 30 1922

BUREAU OF VITAL STATISTICS

Registration District No. 4  
Primary Registration District No. 1008

File No.

Registered No. 129

PROCESSES CONSIDERING A 40-200-2000 HERTZ BANDWIDTH OF 2000 HZ. THE BANDWIDTH OF THE SIGNAL SHOULD BE MUCH GREATER THAN THE BANDWIDTH OF THE NOISE. THE SIGNAL SHOULD BE 10 DB ABOVE THE NOISE.

9-57

3.39

1117  
1118

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**00000000**

58

184 J. A. BDA

40422

TEA, TA EIA

40143-220

MONITORING

[illegible]

1. The following information was obtained from the  
2. records of the Bureau of the Census, Department of  
3. Commerce, Washington, D. C., and is being furnished  
4. to you for your information and use.

10-10-1964

58-1507

4/25/50

20440

4949

DATE OF  
BIRTH

12:15 PM  
12:16 PM

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the situation.

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

44-38861-10

20-47574-2

2000

1. The number of children of the mother was five.

100-47895-10000

10-11-68 10:11 AM

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

558-224-0-8 624  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Payette

City of Payette

No. 505 North 6th St.

Registration District No. 4

State File No. 108134

Hospital.....

Primary Registration District No. 1008 Local Registrar's No. 129

FULL NAME OF CHILD Triplets—stillborn—not named.

(Certificate of no value without full name of child.)

Sex of Child <u>Three Females</u>	<u>Twin Triplet</u> or other? <u>Triplets</u> (To be answered only in event of plural births)	Number in order of birth <u>5</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec. 24</u> (Month) (Day) (Year) <u>1922</u>
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What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 3

FULL NAME FATHER  
John W. Neyman

FULL MAIDEN NAME MOTHER  
Vernie Osmond

RESIDENCE Payette, Idaho

RESIDENCE Payette, Idaho

COLOR White AGE AT LAST BIRTHDAY 50  
(Years)

COLOR White AGE AT LAST BIRTHDAY 32  
(Years)

BIRTHPLACE Indiana

BIRTHPLACE Wyoming

OCCUPATION Salesman

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 1:00 P. on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J.C. Woodward, M.D.  
Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address Payette, Idaho  
Filed Dec. 26 1922 J.C. Woodward  
Registrar.

Registrar.

DO NOT WRITE IN THESE SPACES. ANY WRITING HERE WILL BE DESTROYED WITH THE RECORD. ANY WRITING HERE WILL BE DESTROYED WITH THE RECORD.

SEP 16 1935

CHILD NAME OF CHILD

Registration District No. 1000  
Local Registrar's No. 1234

Sex of Child: Male  
Date of Birth: 1935 (Year), 12 (Month), 15 (Day)

Number of child of this mother, including present birth: 3  
Number of child of this mother now living, including present birth: 3

FATHER NAME: John J. [unclear]  
MOTHER NAME: [unclear]  
RESIDENCE: [unclear]

COLOR: [unclear]  
BIRTHPLACE: [unclear]  
OCCUPATION: [unclear]  
AGE AT LAST BIRTHDAY: [unclear] (Years)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  
I hereby certify that I attended the birth of this child, who was [unclear] on the date above stated.

Physician or Midwife: [unclear]  
Signature: [unclear]  
Date: Dec. 25 1935  
Place: [unclear]



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

5-58-234-038-634  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

108135

County of **Payette**

City of **Payette**

No. **505 North 6th** St.

Registration District No. **4** State File No.

Hospital Primary Registration District No. **1008** Local Registrar's No. **129**

FULL NAME OF CHILD **Triplets—stillborn—not named.**

(Certificate of no value without full name of child.)

Sex of Child <b>Three Females</b>	Twin Triplet or other? <b>Triplet</b> (To be answered only in event of plural births)	Number in order of birth <b>6</b>	Legitimate? <b>Yes</b>	Date of birth <b>Dec. 24</b> (Month) (Day) (Year) <b>1922</b>
-----------------------------------	--	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth **6** Number of child of this mother now living, including present birth **3**

FATHER  
FULL NAME **John W. Neyman**  
RESIDENCE **Payette, Idaho**  
COLOR **White** AGE AT LAST BIRTHDAY **50** (Years)  
BIRTHPLACE **Indiana**  
OCCUPATION **Salesman**

MOTHER  
FULL MAIDEN NAME **Vernie Osmund**  
RESIDENCE **Payette, Idaho**  
COLOR **White** AGE AT LAST BIRTHDAY **32** (Years)  
BIRTHPLACE **Wyoming**  
OCCUPATION **Housewife**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was **Stillborn** at **1:00 P.** on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) **J.C. Woodward, M.D.**  
**Physician**  
(Physician or midwife)

Give names added from a supplemental report.

Address **Payette, Idaho**  
Filed **Dec. 26** **22** **J.C. Woodward**  
1922  
Registrar.

THESE QUESTIONS ARE OF THE MOST IMPORTANT NATURE AND SHOULD BE ANSWERED BY THE BOARD OF DIRECTORS OF THE COMPANY.

1. NAME OF CHARTER  
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 97. NAME OF CHARTER  
 98. DATE OF CHARTER  
 99. NAME OF CHARTER  
 100. DATE OF CHARTER

NAME	DATE OF BIRTH	AGE AT LAST BIRTHDAY	DATE OF DEATH	PLACE OF BIRTH	DATE OF DEATH	PLACE OF DEATH	DATE OF BURIAL	PLACE OF BURIAL	DATE OF CREMATION	PLACE OF CREMATION	DATE OF INTERMENT	PLACE OF INTERMENT
FATHER												
MOTHER												
GRANDFATHER												
GRANDMOTHER												
OTHER												
DATE OF BIRTH	DATE OF DEATH	DATE OF BURIAL	DATE OF CREMATION	DATE OF INTERMENT	DATE OF CREMATION	DATE OF INTERMENT	DATE OF CREMATION	DATE OF INTERMENT	DATE OF CREMATION	DATE OF INTERMENT	DATE OF CREMATION	DATE OF INTERMENT
PLACE OF BIRTH	PLACE OF DEATH	PLACE OF BURIAL	PLACE OF CREMATION	PLACE OF INTERMENT	PLACE OF CREMATION	PLACE OF INTERMENT	PLACE OF CREMATION	PLACE OF INTERMENT	PLACE OF CREMATION	PLACE OF INTERMENT	PLACE OF CREMATION	PLACE OF INTERMENT
DATE OF BIRTH	DATE OF DEATH	DATE OF BURIAL	DATE OF CREMATION	DATE OF INTERMENT	DATE OF CREMATION	DATE OF INTERMENT	DATE OF CREMATION	DATE OF INTERMENT	DATE OF CREMATION	DATE OF INTERMENT	DATE OF CREMATION	DATE OF INTERMENT
PLACE OF BIRTH	PLACE OF DEATH	PLACE OF BURIAL	PLACE OF CREMATION	PLACE OF INTERMENT	PLACE OF CREMATION	PLACE OF INTERMENT	PLACE OF CREMATION	PLACE OF INTERMENT	PLACE OF CREMATION	PLACE OF INTERMENT	PLACE OF CREMATION	PLACE OF INTERMENT

[illegible]

182

Give names added from a supplemental report.

the after birth.

A stillborn child is one that, whether or not it is ever born, breathes not after evidence of life after birth.

When there is no attending physician or nurse, then the father, mother, or another, should make the report.

(Signature)

Address

and

Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

219-209-641 219  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Teton

City of Driggs

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

RECEIVED CERTIFICATE OF BIRTH

JAN

Registration District No. 77

File No. \_\_\_\_\_

Primary Registration District No. 2176

Registered No. 192

FULL NAME OF CHILD

Still Born

(Certificate of no value without full name of child.)

Sex of Child

Female

Twin  
Triplet  
or other?

and

Number  
in order  
of birth  
(To be answered only in event of plural births)

Legiti-  
mate?

Yes

Date of  
birth

Dec 9

1922

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

3-3 Crystal Noddy

Number of child of this mother, including present birth

3

Number of child of this mother now living, including present birth

4

FULL  
NAME

Frank Barnes

FATHER

FULL  
MAIDEN  
NAME

Mitt Barney

MOTHER

RESIDENCE

Driggs, Ida

RESIDENCE

Driggs, Ida

COLOR

White

AGE AT LAST  
BIRTHDAY

30

(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

36

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Utah

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was

Stillborn

M.

on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Chas. Martin

(Physician or midwife)

Give names added from a supplemental report.

Address

Driggs, Ida

Filed

1/2 1922

Martha Marker

Registrar.

Registrar.

1911

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of UtahCity of Driggs

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Registration District No. 77Primary Registration District No. 2174

(No. \_\_\_\_\_ St.)

Not namedState of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 40683Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDSingle

## 6. DATE OF BIRTH

Dec 9 1922  
(Month) (Day) (Year)

## 7. AGE

StillbornIF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).Infant

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Frank Barnes

## 11. BIRTHPLACE OF FATHER

(State or Country)

Utah

## 12. MAIDEN NAME OF MOTHER

Mett Barney

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Barnes

(Address)

Driggs, Ida.

## 15.

Filed Jan 2nd 1923Martha Marker  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec 9 1922  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1922 to Dec 9 1922that I last saw him live on Dec 9 1922

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Chas. M. D.Dec 15 1922 (Address) Driggs, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

Driggs, Ida.

## DATE OF BURIAL

12/10/1922

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

285-2042-263  
PLACE OF BIRTH

RECEIVED

JAN 4 1923

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

108267

County of Teton

City of Teton Falls

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital County

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Registration District No. 37

File No. \_\_\_\_\_

Primary Registration District No. 1085

Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Agalea E. Shearer

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> (To be answered only in event of plural births)	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Nov. 5</u> 192 <u>2</u> (Month) (Day) (Year)
----------------------------	--	--------------------------------	------------------------	--

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth \_\_\_\_\_ Number of child of this mother now living, including present birth \_\_\_\_\_

FULL NAME <u>Mr. Guy Harrison Shearer</u>	FATHER	FULL MAIDEN NAME <u>Agalea Eugenia Bolens</u>	MOTHER
RESIDENCE <u>Teton Idaho</u>		RESIDENCE <u>Teton Idaho</u>	

COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)
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BIRTHPLACE <u>Ill.</u>	BIRTHPLACE <u>Washington Wis.</u>
------------------------	-----------------------------------

OCCUPATION <u>Banker</u>	OCCUPATION <u>House Wife</u>
--------------------------	------------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at \_\_\_\_\_ on the date above stated.  
(~~born~~ or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) A. A. Newberry

(Physician or midwife)  
Teton Ida

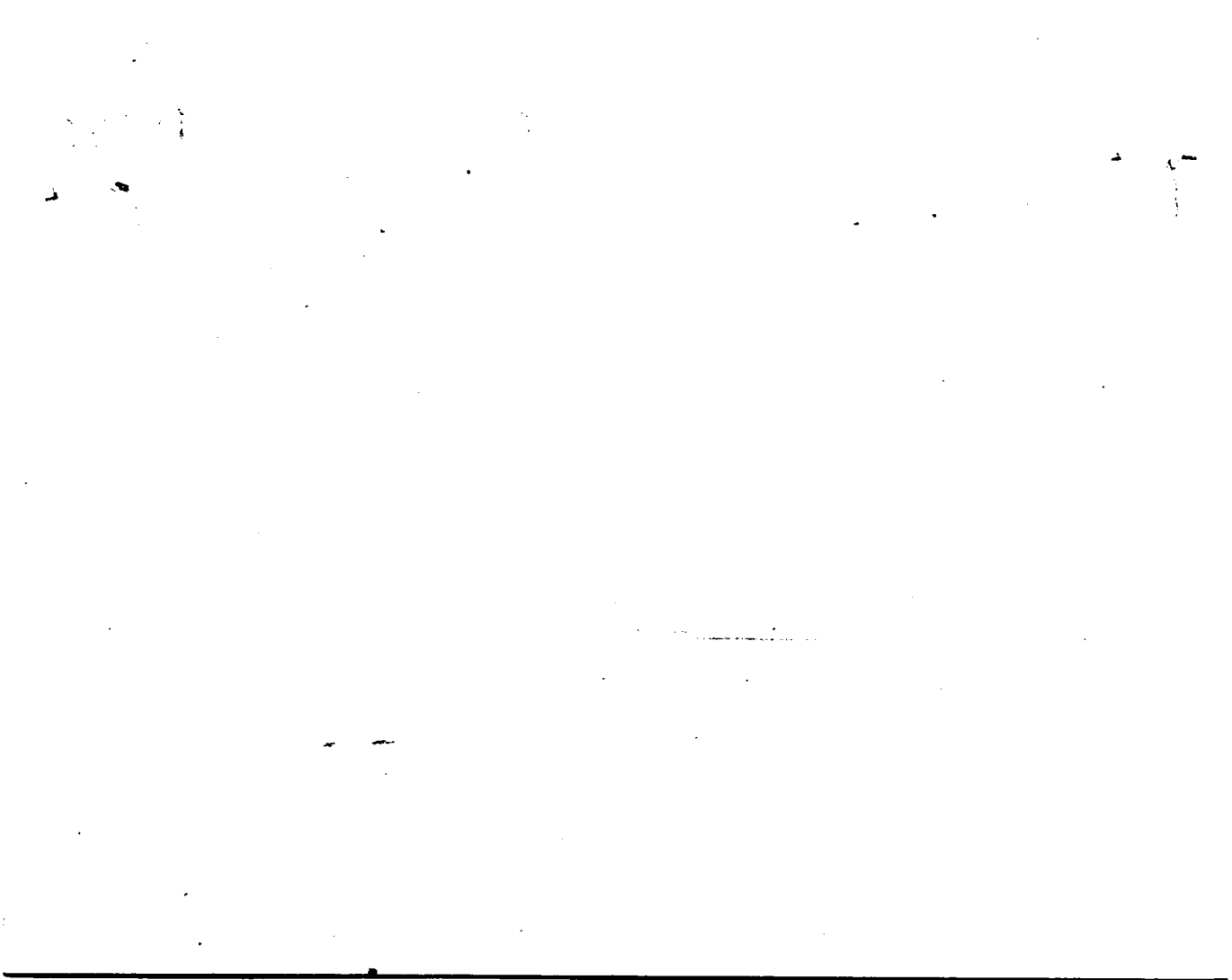
Address \_\_\_\_\_  
Filed Dec. 1 1922 John F. Coughlin

Give names added from a supplemental report.

\_\_\_\_\_, 19\_\_\_\_

Registrar.

Registrar.





FORM V. S. No. 5-A—25 M. 1-19.

RECORDED

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Filer*City of *Cham Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *37*Primary Registration District No. *1085*(No. *37*)

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **40702**  
Registered No. *1096*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Girl*

4. COLOR OR RACE

*White*

5. SINGLE MARRIED, WIDOWED OR DIVORCED

*Single*

(Write the word.)

6. DATE OF BIRTH

*Nov.**5**9<sup>th</sup>*

(Month)

(Day)

(Year)

7. AGE

*Steel Born*

Yrs. Mos. ds.

IF LESS than 1 day  
how many yrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*Ray H. Shearer*

11. BIRTHPLACE OF FATHER

(State or Country)

*Illinois*

12. MAIDEN NAME OF MOTHER

*Agata E. Polens*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Wisconsin*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*John H. Shearer*

(Address)

*Filer, Idaho*

15. *December 1 - 1922*  
Filed

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Nov.**5**19*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

19

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH\* was as follows:

*Steel Born*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*A. A. Newberry*

M. D.

*11/5*

(Address)

*Filer, Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Good Cemetery**Nov 5**19 22*

20. UNDERTAKER

ADDRESS

*J. E. Dink*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

693-222-042-385  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Twin Falls

JAN 4 1923

CERTIFICATE OF BIRTH

City of Twin Falls

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 37

File No. 108268

Hospital County

Primary Registration District No. 1085

Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Baby Wilson. not named.

(Certificate of no value without full name of child.)

Sex of Child

Girl.

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti-  
mate?

yes.

Date of  
birth

Dec - 22

1922

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 1

FULL  
NAME

FATHER

Mr Tom Gilbert Wilson

FULL  
MAIDEN  
NAME

MOTHER

Elizabeth Pearl Cherry

RESIDENCE

Buhl Idaho

RESIDENCE

Buhl Idaho

COLOR

white

AGE AT LAST  
BIRTHDAY 35  
(Years)

COLOR

white

AGE AT LAST  
BIRTHDAY 34  
(Years)

BIRTHPLACE

Griggsville Ill.

BIRTHPLACE

Chillicothe Missouri

OCCUPATION

Farming

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

Born dead at 10<sup>30</sup> A.M. M.  
(Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Chas. R. Scott

(Physician or midwife)

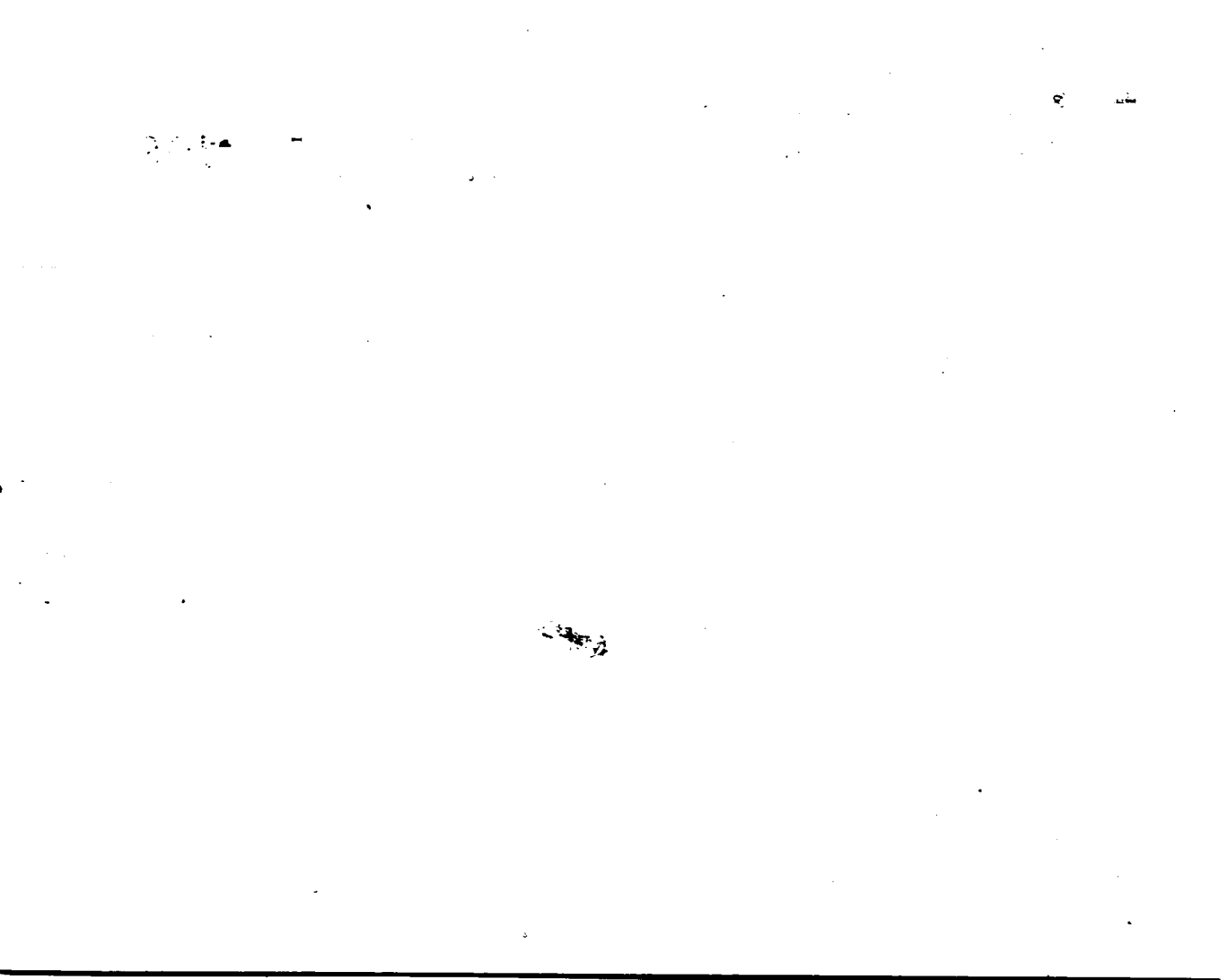
Give names added from a supplemental report.

Address Twin Falls, Ida.

Filed Dec. 30 1922

John V. Coughlin  
Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

RECEIVED

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

JAN 5 1922  
County of Turner  
City of Turner Falls STATE OF IdahoRegistration District No. 39Primary Registration District No. 2087

(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby WilsonState of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 40724

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

6. DATE OF BIRTH

Dec 22 1922  
(Month) (Day) (Year)

7. AGE

- Yrs. - Mos. - ds.IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

L. G. Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Pearl Cherry

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ruby Cherry  
Turner Falls, Idaho

15.

Filed Dec 26 1922J. H. Murphy  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 22 1922  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19\_\_\_\_, to 19\_\_\_\_.

that I last saw him \_\_\_\_\_ alive on 19\_\_\_\_.

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

still birth  
(Ruptured uterus mother)  
(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Chas. R. Scott M. D.Dec 22 1922 (Address) Turner Falls - Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Public CemeteryDec 26 1922

20. UNDERTAKER

ADDRESS

W. W. Willis  
Turner Falls, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

437-225-042-391  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Twin Falls RECEIVED  
City of Twin Falls JAN 4 1923  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 37 File No. 108269  
Hospital County Primary Registration District No. 1085 Registered No. \_\_\_\_\_  
FULL NAME OF CHILD Not Named Baby Mc-Grath.  
(Certificate of no value without full name of child.)

Sex of Child <u>Girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Dec-25</u> 1922 (Month) (Day) (Year)
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What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth... 1 Number of child of this mother now living, including present birth... 0

FULL NAME FATHER <u>Patrick James McGrath</u>	FULL MAIDEN NAME MOTHER <u>Lillian Catherine Crawley</u>
RESIDENCE <u>320 4th East Twin Falls</u>	RESIDENCE <u>320 4th East Twin Falls</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>3.5</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>3.5</u> (Years)
BIRTHPLACE <u>England</u>	BIRTHPLACE <u>London England</u>
OCCUPATION <u>Porter in Hotel</u>	OCCUPATION <u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Born first at 4:20 P.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

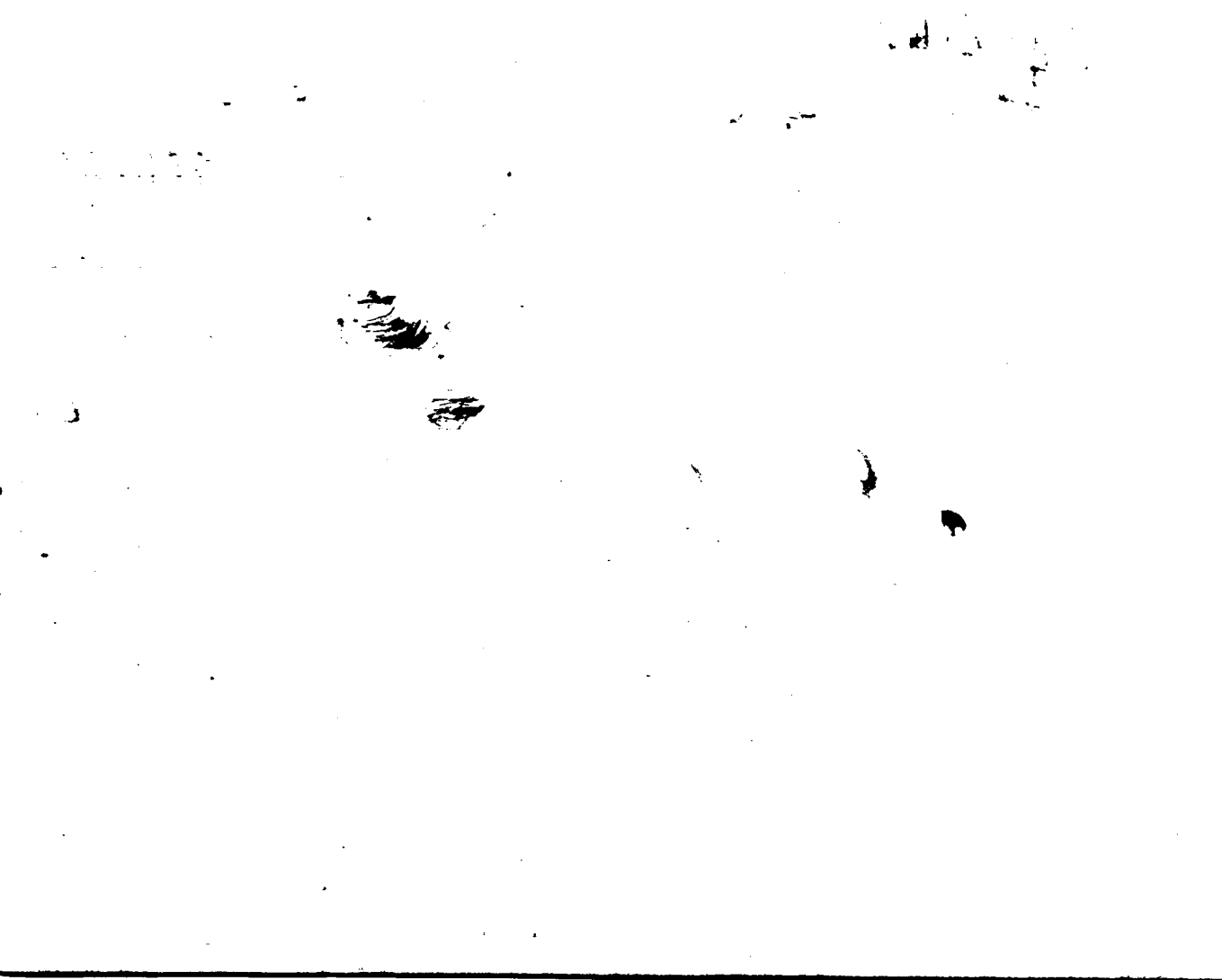
(Signature) J. F. Coughlin  
(Physician or midwife)

Give names added from a supplemental report.

Address Twin Falls, Ida.

Filed Dec. 30 1922 John F. Coughlin  
Registrar.

Registrar.





## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

Registration District No. 37  
 County of Twin Falls Primary Registration District No. 1085  
 City of " (No. County Hospital—) St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Mc Grath

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 40721  
 Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
 (Write the word.)

## 6. DATE OF BIRTH

Dec 25 1922  
 (Month) (Day) (Year)

## 7. AGE

— Yrs. — Mos. — ds.

IF LESS than 1 day  
 how many — hrs.  
 or — min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Twin Falls

## 10. NAME OF FATHER

R. F. Mc Grath

## 11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

## 12. MAIDEN NAME OF MOTHER

Lily Crawley

## 13. BIRTHPLACE OF MOTHER

(State or Country)

England

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. F. Mc Grath

(Address)

Twin Falls 2da

## 15.

Filed Dec 26 1922

John F. Coughlin  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec 25 1922  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Dec 25 1922 to — 19—

that I last saw him alive on — 19—

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) — Yrs. — mos. — ds.

Contributory  
 (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

John F. Coughlin M. D.  
226 24th (Address) Twin Falls

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Twin Falls 2da 12-26 1922

## 20. UNDERTAKER

## ADDRESS

J. F. Coughlin Twin Falls  
2da

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

154-119-001-815  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

S

FEB 7 1923

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL

STATISTICS

CERTIFICATE OF BIRTH

108351

County of Ada

City of Boise

No. St. Luke's St.

Hospital St. Luke's

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. 530

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____ }	Legitimate? <u>yes</u>	Date of birth <u>Oct 19</u> 192 <u>2</u> (Month) (Day) (Year)
--------------------------	---	--	------------------------	--

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth. One Number of children of this mother now living, including present birth None

FATHER  
FULL NAME Julius C. Anderson  
RESIDENCE 1314 N 15 St. Boise Idaho  
COLOR White  
AGE AT LAST BIRTHDAY 27 (Years)  
BIRTHPLACE N. Dak  
OCCUPATION Pharmacist

MOTHER  
FULL MAIDEN NAME Sigrid Hanson  
RESIDENCE 1314 N 15 St. Boise Idaho  
COLOR White  
AGE AT LAST BIRTHDAY 23 (Years)  
BIRTHPLACE Iowa  
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

R. P. French  
417 Overland Bldg. Boise Id  
(Physician or midwife)

Give names added from a supplemental report.

\_\_\_\_\_, 192\_\_\_\_

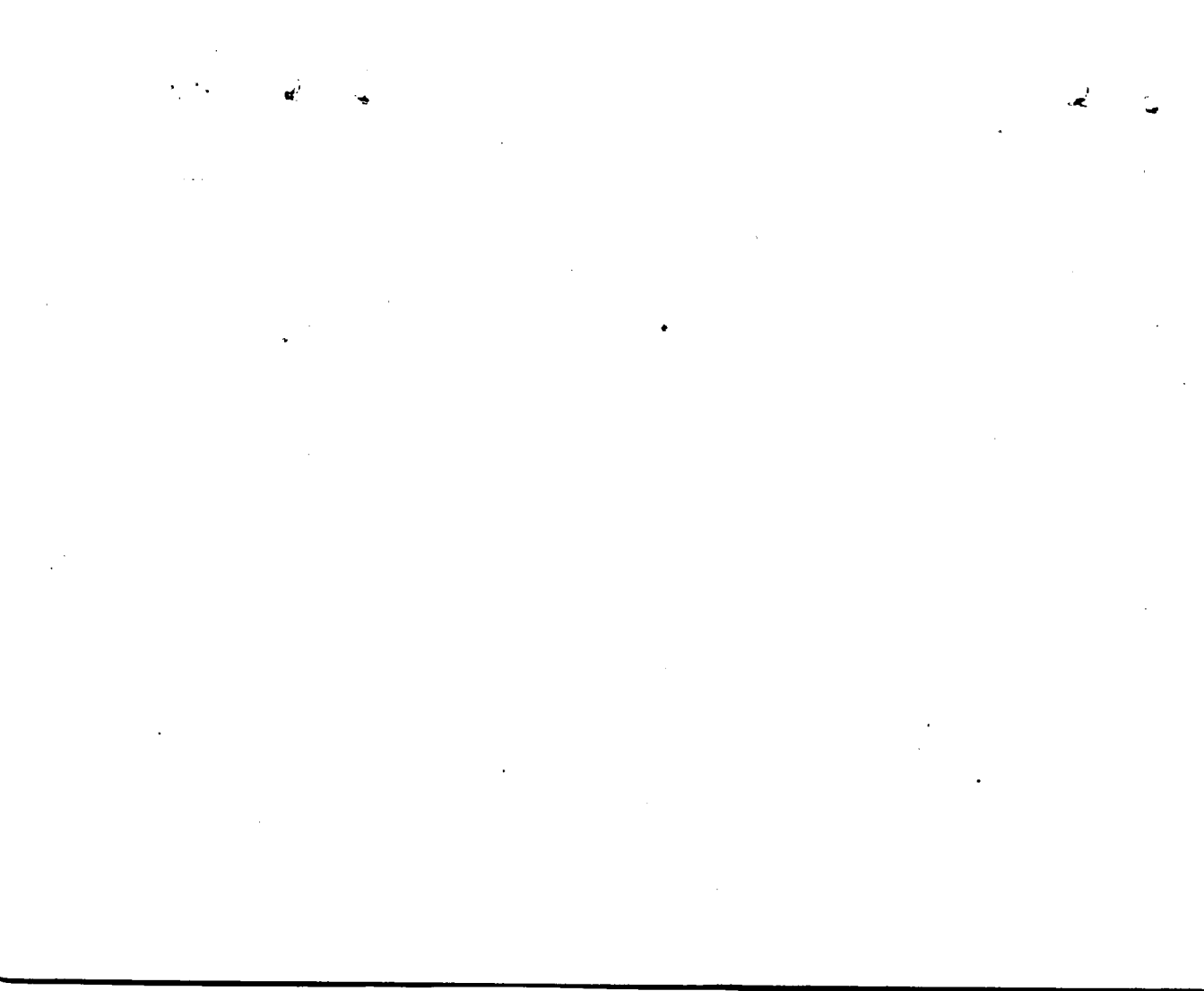
Address \_\_\_\_\_

Filed 2-3 1923

Registrar.

R. H. Pratt

Registrar.



French

State of Idaho  
BOARD OF HEALTH  
Bureau of Statistics  
39487

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada  
City of Boise

Registration District No. 2

Primary Registration District No. 1004  
(No. St. Lukes Hospital)

File No. \_\_\_\_\_

Registered No. 249

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Infant Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

6. DATE OF BIRTH Oct - 19 1922  
(Month) (Day) (Year)

7. AGE \_\_\_\_\_ Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds.  
IF LESS than 1 day how many \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8. OCCUPATION None  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Boise Idaho  
(State or Country)

10. NAME OF FATHER Julius C. Anderson

11. BIRTHPLACE OF FATHER North Dakota  
(State or Country)

12. MAIDEN NAME OF MOTHER Sigrid Hansen

13. BIRTHPLACE OF MOTHER Iowa  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Anderson  
(Address) Boise, Idaho

15. Filed Oct - 20 1922 T. W. Pratt  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 19 22  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1922 to Oct 19 1922  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date stated above, at \_\_\_\_\_ M.  
The CAUSE OF DEATH\* was as follows:

Still Born at full term. Probably from suffocation during version and delivery  
(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. 0 ds.

Contributory (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) P. French M. D.  
10/20/1922 (Address) Boise

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 10/20 1922

20. UNDERTAKER Summers & Krebs ADDRESS Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11

County of *Owyhee*

RECEIVED

JAN 15 1923

CERTIFICATE OF BIRTH

S 108725

City of *Hot Springs*

389-211-037-655

No. \_\_\_\_\_ St. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

*Stillborn Child*

Sex of Child

*Girl*Twin  
Triplet  
or other?

and

Number  
in order  
of birth*Second  
Child*Legiti-  
mate?*Yes*Date of  
Birth*Oct. 11 1922*  
(Month) (Day) (Year)FULL  
NAME*FATHER  
Conrad Kahn*

RESIDENCE

*Hot Springs*

COLOR

*Light*AGE AT LAST  
BIRTHDAY*47*  
(Years)

BIRTHPLACE

*Germany*

OCCUPATION

*Farmer*FULL  
MAIDEN  
NAME*MOTHER  
Katherine E. Wendell*

RESIDENCE

*Hot Springs*

COLOR

*Dark*AGE AT LAST  
BIRTHDAY*31*  
(Years)

BIRTHPLACE

*Chicago Ill*

OCCUPATION

*Bookkeeper*

Number of child of this mother, including present birth, \_\_\_\_\_

Number of children of this mother now living, including present birth, \_\_\_\_\_

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

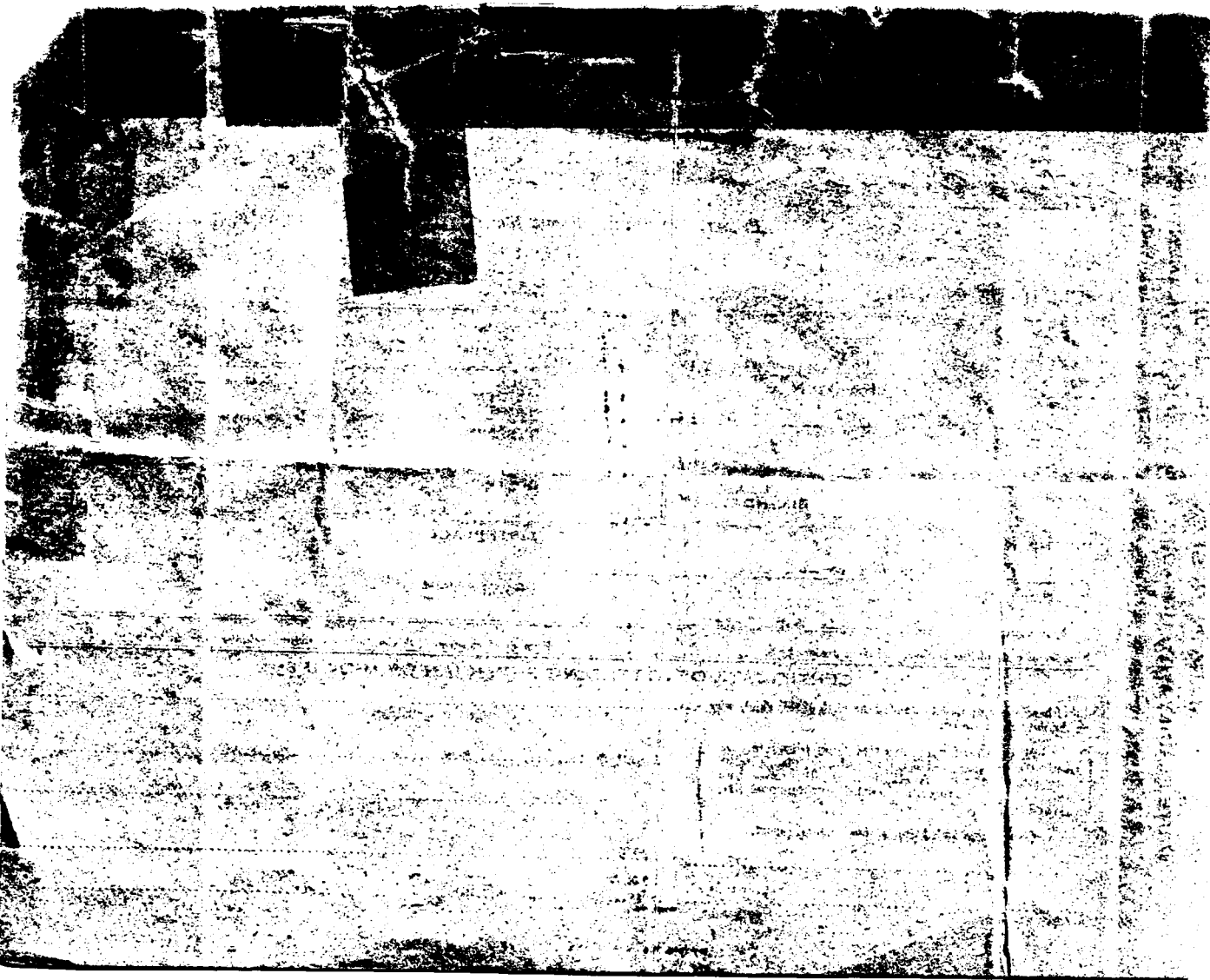
(Signature)

*Dr. Barker of Bureau*  
*was the attending physician*  
(Physician or midwife)

Given names added from a supplemental report.

Address \_\_\_\_\_

Filed *Jan. 15 1923**F. A. L. M. D.*  
*State* Registrar





66K-129-010-219

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-4-4-37

County of Bonneville

FEB 21 1923

CERTIFICATE OF BIRTH

S108921

City of Idaho FallsBUREAU OF VITAL  
STATISTICSRegistration District No. 7 3

File No. ....

No. Cliff ..... St.Primary Registration District No. 2150Registered No. 7

Hospital .....

FULL NAME OF CHILD

Clyde L Roy JoubtSex of  
Child MaleTwin  
Triplet  
or other?  
(To be answered only in event of plural births)and { Number  
in order  
of birthLegiti-  
mate? yesDate of  
Birth Dec 29 1922  
(Month) (Day) (Year)FULL NAME FATHER  
Geo Donald JoubtFULL MAIDEN NAME MOTHER  
Beatrice BartlettRESIDENCE  
Idaho Falls IdaRESIDENCE  
Idaho Falls IdaCOLOR st AGE AT LAST  
BIRTHDAY 21  
(Years)COLOR st AGE AT LAST  
BIRTHDAY 18  
(Years)BIRTHPLACE  
Ballard WashBIRTHPLACE  
OklahomaOCCUPATION  
Oil driverOCCUPATION  
housewife

Number of child of this mother, including present birth.....1. Number of children of this mother now living, including present birth.....1.

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born dead at 4 9 M.  
on the date above stated. (Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc., should  
make this return. A stillborn child is one that  
neither breathes nor shows other evidence of life  
after birth.(Signature) Cliff Joubt

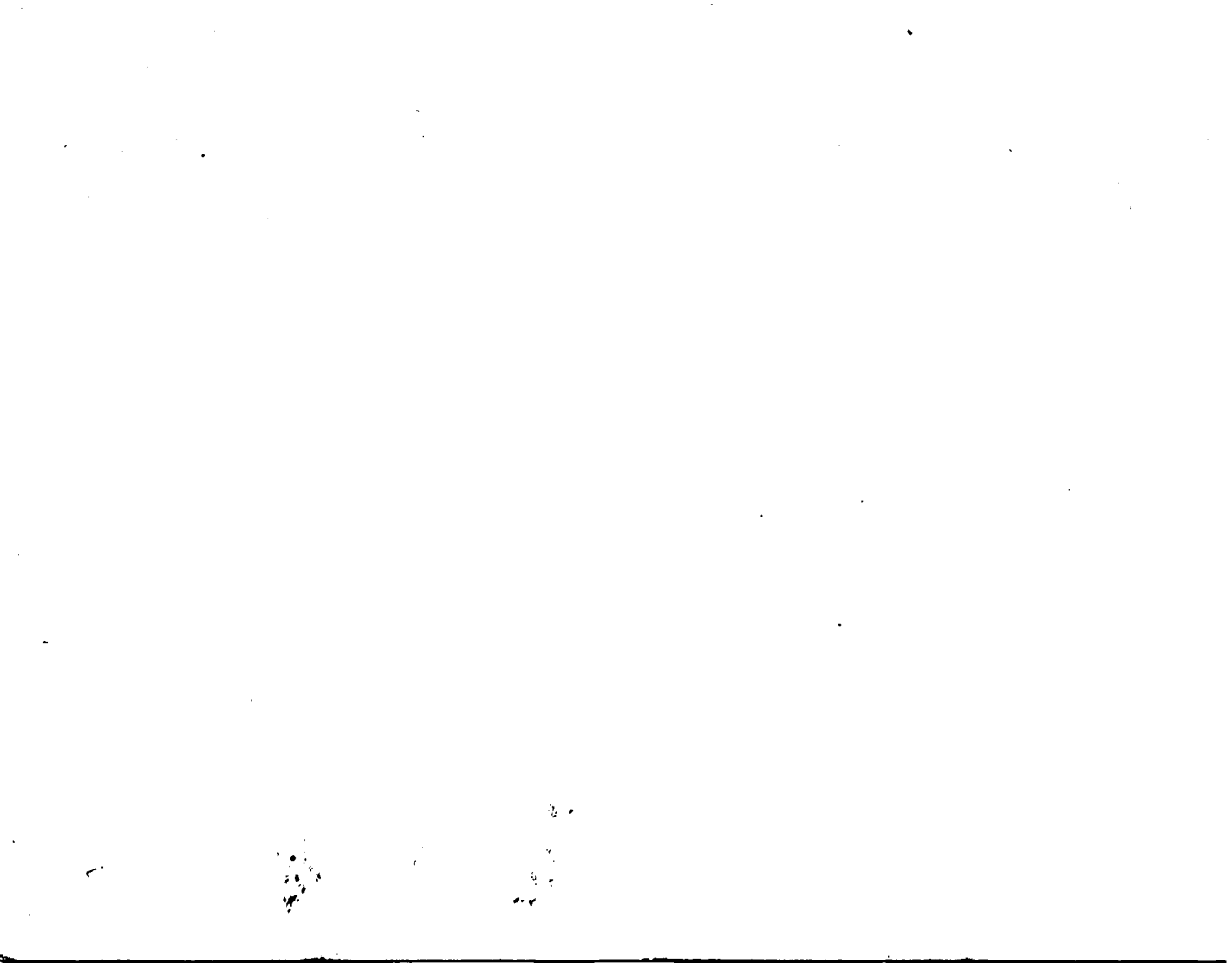
(Physician or midwife)

Given names added from a supplemental report.

Address Idaho FallsFiled 2/14 23 W. J. Joubt

Registrar

Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

389-112-010-652  
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
MAR 8 1923  
BUREAU OF VITAL  
STATISTICS

S

109459

County of Bonanza  
City of Idaho Falls  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 73 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 215-0 Registered No. 11A

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Boy</u>	Twin number? _____ (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>11/13</u> 192 <u>2</u> (Month) (Day) (Year)
-------------------------	--	--------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? .....

Number of child of this mother, including present birth..... Number of child of this mother now living, including present birth.....

FATHER		MOTHER	
FULL NAME <u>Albert Martin Christensen</u>	FULL MAIDEN NAME <u>Idella Webster</u>	FULL NAME	FULL MAIDEN NAME
RESIDENCE <u>Idaho Falls Idaho</u>	RESIDENCE <u>Idaho Falls Idaho</u>	RESIDENCE	RESIDENCE
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>38</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>35</u> (Years)	COLOR	AGE AT LAST BIRTHDAY
BIRTHPLACE <u>Hyde Park Utah</u>	BIRTHPLACE <u>Grant Idaho</u>	BIRTHPLACE	BIRTHPLACE
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Shelborn at 11 a. M.  
on the date above stated. (Born alive or stillborn)

{ When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth. }

(Signature) J. C. Hallister

(Physician or midwife)

Give names added from a supplemental report.

Address Idaho Falls Idaho

Filed 2120 1923 W. J. Harrison  
Registrar. Registrar.

000000

WILL TRAVEL TO CHINA

to send this information		-Legal Section	to send this information		to send this information
--------------------------------	--	-------------------	--------------------------------	--	--------------------------------

Scanned with CamScanner

Number of calls of this member in this member's group: 1

Number of calls of this member in this member's group: 1

FULL NAME	MOTHER
FULL NAME	PATHER
FULL NAME	FATHER
FULL NAME	MOTHER

NAME	RESIDENCE
NAME	RESIDENCE

CONFIDENTIAL

.....

BIRTHPLACE

OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

...now blind and to find out whether I had returned to the ...

(S) (U) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z)

.....

100-443888-100

SECRET

SECRET

\_\_\_\_\_

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

533-206-010-596  
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
MAR 8 1923  
BUREAU OF VITAL STATISTICS

S

109491

County of Koonville  
City of Idaho Falls  
No. 73 St. Registration District No. 2150 File No. 66  
Hospital Central City Primary Registration District No. 2150 Registered No. 66

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Girl</u>	Twin <u>no</u> or other? <u>no</u> (To be answered only in event of plural births)	and	Number in order of birth <u>2nd</u>	Legitimate? <u>yes</u>	Date of birth <u>3/6</u> 192 <u>3</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? .....

Number of child of this mother, including present birth... 3 ... Number of child of this mother now living, including present birth... 3 .....

FATHER		MOTHER	
FULL NAME <u>Ernest Ellis</u>	FULL MAIDEN NAME <u>Marie Vroman</u>	FULL NAME <u>Ernest Ellis</u>	FULL MAIDEN NAME <u>Marie Vroman</u>
RESIDENCE <u>Idaho Falls Idaho</u>	RESIDENCE <u>Idaho Falls Ida</u>	RESIDENCE <u>Idaho Falls Idaho</u>	RESIDENCE <u>Idaho Falls Ida</u>
COLOR <u>White</u>	COLOR <u>White</u>	COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>40</u> (Years)	AGE AT LAST BIRTHDAY <u>35</u> (Years)	AGE AT LAST BIRTHDAY <u>40</u> (Years)	AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE <u>Central City Neb.</u>	BIRTHPLACE <u>Mullen Neb.</u>	BIRTHPLACE <u>Central City Neb.</u>	BIRTHPLACE <u>Mullen Neb.</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... still born ... at... M. ...  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) P. C. Hallister  
P. C. Hallister  
(Physician or midwife)

Give names added from a supplemental report.

Address Idaho Falls Idaho

Filed 2/20 1923 W. J. ...  
Registrar.



455-1031010-942

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of BonnevilleCity of Idaho FallsMAR 8 1923  
BUREAU OF VITAL  
STATISTICS

## CERTIFICATE OF BIRTH

S

109548

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 73

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2140 Registered No. 147

## FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>8</u> <u>3</u> (Month) (Day) (Year) <u>1922</u>
--------------------------	---	-----	--------------------------------	----------------------------	--

FULL NAME Wm. F. FATHER  
RESIDENCE Idaho Falls R.F.D.  
COLOR White AGE AT LAST BIRTHDAY 23 (Years)  
BIRTHPLACE Oklahoma  
OCCUPATION Farmer

FULL MAIDEN NAME Mary Russell  
RESIDENCE Idaho Falls  
COLOR White AGE AT LAST BIRTHDAY 18 (Years)  
BIRTHPLACE Malad Idaho  
OCCUPATION Housewife

Number of child of this mother, including present birth. / Number of children of this mother now living, including present birth. /

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 3<sup>30</sup> a.m. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mrs R W Dunning  
(Physician or midwife)

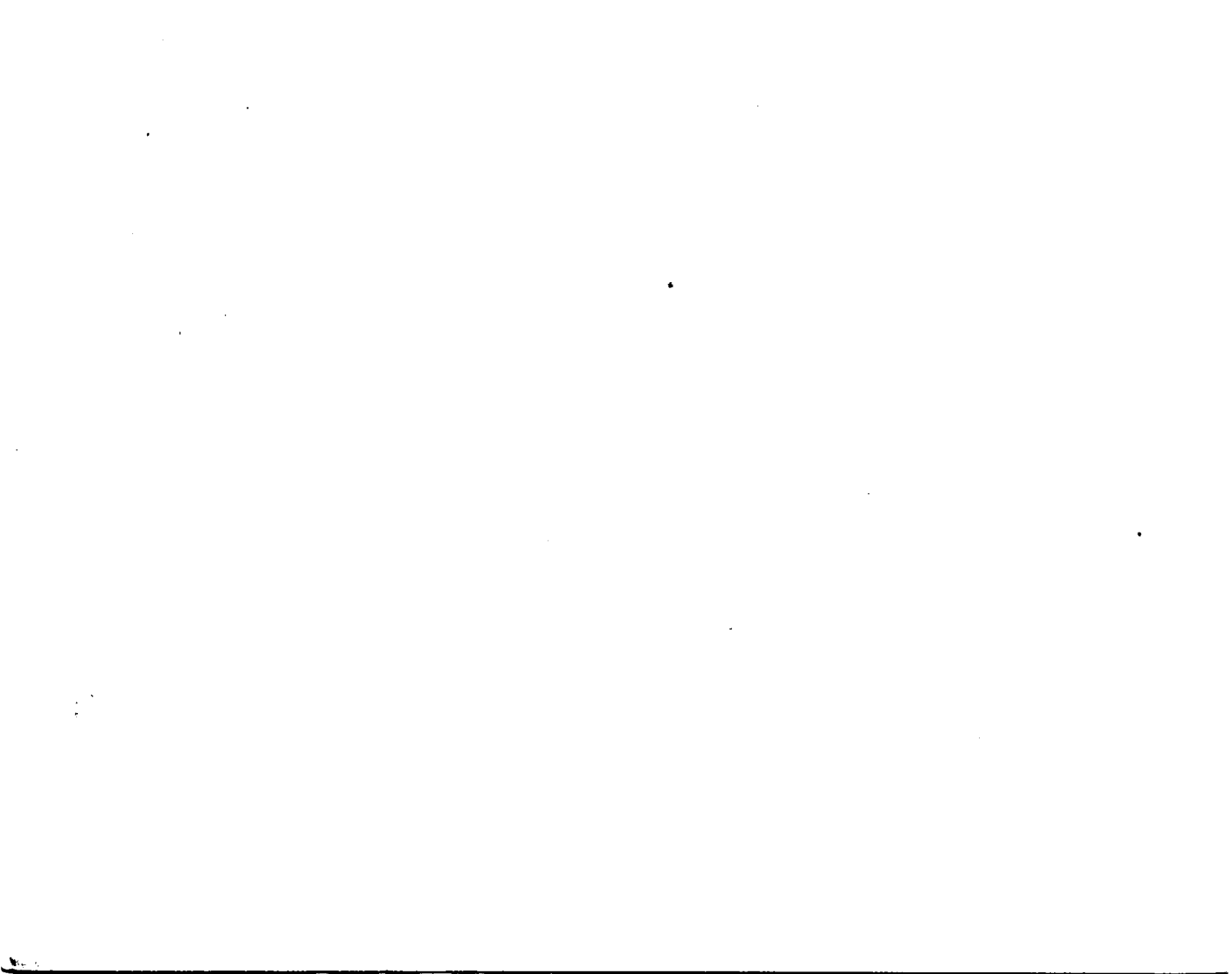
Given names added from a supplemental report.

19

Address Idaho  
Filed 2/24 19 23 at  
Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.





## PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

419421-026649

County of *Jefferson*City of *Boise*No. *1*Hospital *home*

RECEIVED

MAR 19 1923

BUREAU OF VITAL STATISTICS

STATISTICS

Primary Registration District No.

CERTIFICATE OF BIRTH

98

File No.

108963

Registered No.

1

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <i>m</i>	Twin Triplet or other? <i> }</i> and <i>(Number in order of birth)</i>	Legiti- mate? <i>Yes</i>	Date of birth <i>11/21</i> 192 <i>2</i> (Month) (Day) (Year)
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What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *4* Number of children of this mother now living, including present birth *0*FATHER  
FULL NAME *William Elbert Marler*RESIDENCE *Reuby Ida*COLOR *White* AGE AT LAST BIRTHDAY *36* (Years)BIRTHPLACE *Clifton Ida.*OCCUPATION *Coburn*MOTHER  
FULL NAME *Mary Dorothy Turnandy*RESIDENCE *Reuby Ida*COLOR *White* AGE AT LAST BIRTHDAY *32* (Years)BIRTHPLACE *Berry Ranchhair Eng*OCCUPATION *home*

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *still birth* at *3 a* M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

*O. C. Case M.D.*

(Physician or midwife)

Give names added from a supplemental report.

, 192

Address

Filed

3/10 1923

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

2

DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF IOWA

PLACE OF BIRTH

CERTIFICATE OF BIRTH

1938

Registration No. \_\_\_\_\_

Birth Date \_\_\_\_\_

CHILD

Sex \_\_\_\_\_  
Color \_\_\_\_\_  
Weight \_\_\_\_\_  
Length \_\_\_\_\_

Signature \_\_\_\_\_  
Date \_\_\_\_\_

Signature \_\_\_\_\_  
Date \_\_\_\_\_

Signature \_\_\_\_\_  
Date \_\_\_\_\_

Signature \_\_\_\_\_  
Date \_\_\_\_\_

Signature \_\_\_\_\_  
Date \_\_\_\_\_

Signature \_\_\_\_\_  
Date \_\_\_\_\_

Signature \_\_\_\_\_  
Date \_\_\_\_\_

Signature \_\_\_\_\_  
Date \_\_\_\_\_

RECEIVED

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Jefferson Registration District No. 28  
 City of Rexburg Registration District No. 2176 St.

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 41412  
 Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M W Single  
 (Write the word.)

## 6. DATE OF BIRTH

11-21-1922  
 (Month) (Day) (Year)

## 7. AGE

stillborn IF LESS than 1 day  
 how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

Wm A. Marler

## 11. BIRTHPLACE OF FATHER

(State or Country) Ida

## 12. MAIDEN NAME OF MOTHER

Mary D. Fernandez

## 13. BIRTHPLACE OF MOTHER

(State or Country) England

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Marler  
 (Address) Rexburg, Idaho

## 15.

Filled 3/11/23 Ray H. Fisher  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

11-21-22  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....  
 that I last saw h..... alive on 19.....  
 and that death occurred on the date stated above, at..... M.  
 The CAUSE OF DEATH\* was as follows:

stillborn  
 (Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) G. J. Call M. D.

11-21-22 (Address) Rexburg

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Rexburg 11-21-22

## 20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for  
each and the number of each, in order of birth stated.

844-204.010-863  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

**RECEIVED**  
APR 9 1925  
BUREAU OF VITAL STATISTICS

County of Bonneville  
City of Ida Falls  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 73 State File No. 130507

Hospital \_\_\_\_\_ Primary Registration District No. 2120 Local Registrar's No. 70

FULL NAME OF CHILD \_\_\_\_\_  
(Certificate of no value without full name of child)

Sex of Child girls { Twin Triplet } and { Number in order of birth 2 } Legitimacy yes Date of birth 2-4-192  
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? argyrol

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	<u>W. A. Hudman</u>	FULL MAIDEN NAME	<u>Alice May Holley</u>
RESIDENCE	<u>Ida Falls, Ida.</u>	RESIDENCE	<u>Ida Falls, Ida.</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
BIRTHPLACE	<u>Ogden Ut.</u>	BIRTHPLACE	<u>Ogden Ut.</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>
AGE AT LAST BIRTHDAY	<u>26</u> (Years)	AGE AT LAST BIRTHDAY	<u>28</u> (Years)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.  
I hereby certify that I attended the birth of this child, who was { Born alive } at 4:00 + 4:30 A.M. on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. \_\_\_\_\_, 192\_\_\_\_

Address Ida Falls, Ida.  
Filed Mar. 11 1925 W. A. Kinnaird  
Registrar. Registrar.

RECEIVED  
BUREAU OF VITAL STATISTICS  
DEPARTMENT OF PUBLIC WELFARE  
STATE OF MICHIGAN

19 095 0  
CERTIFICATE OF BIRTH

State File No.

City Registration District No. 10 Local Board

LIST NAME OF CHILD

(Indicate if no value without full name of child)

[illegible]

12999 at both new nucleoside laboratories and W

Number of child of this mother now living including present birth

**МОТНЕР**

NAME, MIDDLE, FULL

## RESIDENCE

COLON

TRAJTA 30A  
YACHTNIB

**SECRET**

NOTA 44500

FATHER

1117  
241434

10450182Я

50.00

B-52D  
 100-1000000

**BIRTHPLACE**

DECLASSIFICATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of said child, who was born at [redacted] Illinois

the names added from a supplemental report. \* When there was no attending physician or midwife, the father, doctor, or somebody makes this return. A midwife or child is one that neither parent nor shows other evidence of life after birth.

(Physician or midwife)

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

844-204-010-863  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
**RECEIVED**  
APR 9 1925  
BUREAU OF VITAL STATISTICS

S

County of Bonanza  
City of Idaho Falls  
No. 23 St. Registration District No. 23 File No. 130508  
Hospital 2140 Primary Registration District No. 2140 Registered No. 74

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>girl</u> <u>Boys</u>	Twin <u>Yes</u> { and { Number in order of birth <u>1</u> <u>as others?</u> (To be answered only in event of plural births)	Legitimated <u>yes</u>	Date of birth <u>2/4/1925</u> (Month) (Day) (Year)
What bactericidal solution was used in eyes? <u>Argyrol</u>			
Number of child of this mother, including present birth <u>3</u>		Number of child of this mother now living, including present birth <u>1</u>	
FATHER FULL NAME <u>W. A. Hudman</u> RESIDENCE <u>Idaho Falls Ida</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>26</u> (Years) BIRTHPLACE <u>Ogden Utah</u> OCCUPATION <u>Farmer</u>		MOTHER FULL MAIDEN NAME <u>Alice May Holley</u> RESIDENCE <u>Idaho Falls Ida</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>28</u> (Years) BIRTHPLACE <u>Ogden Utah</u> OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 4:00 - 4:00 AM on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) L. C. Hallister  
M. D.  
(Physician or midwife)

Give names added from a supplemental report.

Address Idaho Falls Idaho

Filed Mar 11 1925

Registrar.

Registrar.

DECEASED  
 DO NOT SIGN THIS CERTIFICATE IF THE CHILD IS DEAD OR IF THE CHILD IS A FETUS  
 IF THE CHILD IS A FETUS, THE CERTIFICATE SHOULD BE FILED IN THE DEPARTMENT OF HEALTH  
 AND HUMAN SERVICES, DIVISION OF VITAL RECORDS, WASHINGTON, D.C. 20460

PLACE OF BIRTH

County of \_\_\_\_\_

City of \_\_\_\_\_

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Time of Birth \_\_\_\_\_

Has blood relationship with child in way \_\_\_\_\_

Is mother of this child \_\_\_\_\_

FATHER

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

AGE AT LAST BIRTHDAY \_\_\_\_\_

COLOR \_\_\_\_\_

BIRTHPLACE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_

as the date above stated.

Signature \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

RECEIVED  
 DEPARTMENT OF PUBLIC WELFARE  
 BUREAU OF VITAL STATISTICS  
 STATE OF IDAHO

CERTIFICATE OF BIRTH

100203

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Full name of mother \_\_\_\_\_

Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Time of Birth \_\_\_\_\_

Has blood relationship with child in way \_\_\_\_\_

Is mother of this child \_\_\_\_\_

MOTHER

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

AGE AT LAST BIRTHDAY \_\_\_\_\_

COLOR \_\_\_\_\_

BIRTHPLACE \_\_\_\_\_

OCCUPATION \_\_\_\_\_